Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ____Sherrie Powell_____ Day/Date: __Monday 10/13/2025_____

Number of Clinical Hours Today: _8_ Number of patients seen_6_

Care Setting: Hospital _X__ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: __Erica Aiken_____

Clinical Focus: Wound ____ Ostomy ____ Continence __X__

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. Once you have completed the form, save the document by clinical date and preceptor. Submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters, types of patients seen, and any additional activities.

Today during clinical, we were able to see and evaluation 6 patient consults in the acute care setting of the hospital. I had two flexi-seal evaluations, two wound VAC dressing changes, an ostomy teaching for a patient who had a revision from a colostomy to an ileostomy, and a facial wound. Both flexi-seal evaluations showed contraindications to flexi-seal insertion during chart review. One wound VAC dressing change was to a right foot post trans-metatarsal amputation from gaseous gangrene. The VAC was with Vashe instillation because the doctors were trying to preserve as much tissue as possible before the next debridement and washout. The next wound VAC was on the chest from a pocket hematoma that the patient developed after ICD placement. My next consult involved a patient who had large T-cell Carcinoma with a fungating lesion on his face. My last patient needed ostomy teaching for a new ileostomy. This patient had a loop colostomy previously but had to get a revision with a new loop ileostomy creation.

Types of patients: ileostomy, wound VAC, cancer tumor, fecal incontinence, flexi-seal

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

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Chart note:

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	1
Activity	2
Mobility	2
Nutrition	2
Friction/Shear	2
Total	12

WOC is consulted to evaluate for flexiseal insertion. Patient is a 75-year-old male admitted with GI bleed. Patient has a past medical history of anemia, arteriovenous malformation (AVM) of colon, diverticulitis, diverticulosis, gastroesophageal reflux disease (GERD), hemorrhoids, cerebrovascular accident (CVA), left side hemiparesis, myelodysplastic syndrome (MDS), GI bleed, and duodenal ulcer. Per chart review, patient is not a candidate for Flexi-seal insertion due to GI bleed and colonic AVM. Patient noted with multiple scattered partial thickness tissue loss over coccygeal region. Wounds are red, irregularly shaped and shiny with scant amount of serous drainage; no odor note. Wound edges poorly defined, periwound is erythematous with no fluctuance or induration. Dimethicone protectant ordered for incontinence episodes. WOC recommends external fecal incontinence collector that can be initiated by unit nursing staff.

Using the information from the chart note, develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders.

WOC Plan of Care (include specific products)

External Rectal Pouch Recommendations:

*Wash hand before and after patient care
*Wipe the patient's entire peri area with the disposable washcloths and water ONLY (this removes residue left behind by incontinence wipes/zinc).
* Pat dry thoroughly.
*Apply Stomahesive powder over denuded skin, lightly brushing off excess with dry disposable wash cloth.
*Dab 3M Cavilon No-Sting barrier skin film over powdered areas to seal in powder, also apply Cavilon to areas that will potentially come in contact with the pouch and let dry.
*Apply Cavilon No-Sting barrier skin film to the peri area, let dry.
*It can be helpful to have a second person to spread buttocks apart if needed for a better seal.
*Place rectal bag, holding hands over for 1-2 minutes to allow the skin barrier to seal. It is normal to have to have to replace it every 24-48 hours.
*Notify WOC with any questions or concerns
*Notify WOC, if this application is unsuccessful., notify WOC Vocera WOC with any questions or concerns.

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Describe your thoughts related to the care provided. What would you have done differently

I had a very good day for patient and staff education. My ostomy teaching went well, and I also had a new nurse who was at the bedside during my teaching. I was able to show her how to properly measure the pouch barrier to fit around the stoma. I also had to explain and give information to staff on why the patient was not able to get a Flex-seal. I would not have done anything differently.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

What was your goal for the day?

My goal for today was to get my continence journals closer to completion. My goal was met.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

I was not aware until after doing a stoma marking that we needed to do a stoma marking journal. My goal is to get another stoma marking to get that journaling opportunity completed.

For instructor use only. Do not remove or edit:

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen	✓	
• Describes the encounter including assessment, interactions, any actions, education provided and responses	✓	
• Completes Braden Scale for inpatient encounter	✓	
• Includes pertinent PMH, HPI, current medications and labs	✓	
• Identifies specific products utilized/recommended for use	✓	
• Identifies overall recommendations/plan	✓	
Plan of Care Development:		
• POC is focused and holistic	✓	
• WOC nursing concerns and medical conditions, co-	✓	

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morbidities are incorporated		
• Braden subscales addressed (if pertinent)	✓	
• Statements direct care of the patient in the absence of the WOC nurse	✓	
• Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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