Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ____Carla Edeh_____ Day/Date: _10/24/25_____

Number of Clinical Hours Today: _8_ Number of patients seen__5__

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

Preceptor: ____Elizabeth Kulling, RN, BSN, WWOCN, CWS_____

Clinical Focus: Wound __X__ Ostomy ____ Continence ____

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.

During this clinical day, I, woc nursing student, was hands with Elizabeth Kulling, RN CWOCN with care of multiple patients requiring advanced ostomy and wound management: *Remember, "WOCN" is a protected acronym for the professional society. The individual practicing nurse should not be referred to as such.*

chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.wocncb.org/pdf/position-statements/Position_Statement_WOCN_%20Registered_Trademark_Use_Guidelines.pdf

We evaluated a patient, along with Zack, RN cwocn, who experiencing persistent daily leakage at the end jejunostomy site. Contributing factors included significant abdominal contour irregularities with multiple creases and skin folds impacting pouching system adherence. Collaborative planning focused on optimizing pouching technique, barrier selection, and accessory use.

We collaborated with another assessed and managed a leaking enterocutaneous fistula pouch. Dressing and pouching strategies were discssed to promote improved containment and skin protection.

We assisted a patient with ongoing leakage from their end ileostomy appliance. Peristomal skin integrity and pouch fit were evaluated, and modifications were initiated to achieve a more secure seal.

Kock (K) Pouch – Discharge Education: My preceptor completed discharge teaching for a patient transitioning home with a K-pouch continent diversion. Reviewed catheterization technique, stoma care, signs of complications, and community resources to ensure confidence and self-management upon discharge.

We performed Negative Pressure Wound Therapy (NPWT) for a scheduled dressing change on a patient with a left mid-chest wound VAC.

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I was directly hands-on for all patient encounters.

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.

Chart note:

WOC Nurse Consultation Note
Date of Consult: 10/24/2025
Consulting Service: Elizabeth Kulling, RN, CWOCN and Carla Edeh, RN woc nursing student consulted for leaking fistula pouch

History:
WOC nurse ←*see my above comment and link, make sure this is not documented as such (use "CWOCN" or "WOC nurse"). It can have a negative effect on your own professional practice.* was consulted for a **73-year-old female** with a significant past medical history of LDA, HTN, renal mass status post laparoscopic left retroperitoneal radical nephrectomy (2004), and active tobacco use. Patient was a direct admission from Mercy Hospital for evaluation and management of an abdominal wall abscess complicated by colo-cutaneous fistula formation. Patient also with a sacral pressure injury.

Current Medication List:
Clonidine, Vitamin D, Ferrous sulfate, HCTZ, Ibuprofen, Metoprolol, Potassium chloride, Torsemide, Doxycycline monohydrate, Hydroxychloroquine, Nexium, Prednisone

WOC nurse consulted for concerns regarding pouch integrity and potential leakage around a known colocutaneous fistula. On assessment, the existing pouch was noted to be nearly leaking at the midline. The fistula is positioned in close proximity to the midline abdominal wound, increasing risk of undermining and skin compromise. Bedside RN also reported concern for early leakage. Due to these findings and the unavailability of a postoperative pouching system, the pouch was removed and replaced during today's visit with a modified system to optimize containment and protect periwound skin.

Assessment
- **Type of Fistula:** Colocutaneous fistula
  - **Location:** Lower right abdomen
  - **Wound Bed:** Not involved
  - **Perifistular Skin:** Intact, clear, no erythema or breakdown

Perifistula Contour: Rounded with areas of loose, mobile tissue
Effluent Characteristics: Thin, liquid, brown stool output
Tissue Quality: Soft, loose supportive tissue at the abdominal wall

Fistula Management Care Completed Today

Stomahesive half-sheet wedge applied inferiorly to support loose tissue
Hollihesive wedges placed circumferentially with overlapping technique for contour correction
Bow-tie–shaped wedge positioned between drain sites for additional support
Stomahesive paste applied for caulking/sealing
Coloplast flat postoperative pouch with viewing window applied
Thin smear of paste beneath wafer to improve adhesion
Mefix tape used to frame edges and reinforce seal
Connected to gravity drainage system for output diversion

Next scheduled pouch change: Weekly and PRN for leakage or loosening

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	1
Activity	1
Mobility	2
Nutrition	1
Friction/Shear	2
Total	10

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)

All of the green highlight reflects what you did – this needs to be in your note. The POC is your direction as the specialist. It should be in the POC section.

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Nursing Orders:

Perifistular Skin Care

Cleanse skin with mild soap and water; pat thoroughly dry
Apply Stomahesive powder to irritated areas as needed; gently dust off excess
Apply **3M Cavilon** no-sting skin barrier to surrounding irritated skin

Pouching System – Recommended Setup

Stomahesive wedges to off-load skin tension and maintain seal
Caulk with Stomahesive paste at skin irregularities
ConvaTec Durahesive flat flange, trimmed at midline to accommodate wound proximity
High-output (HVOP) pouch connected to gravity drainage bag
Hytape applied at medial edge to secure seal

Expected Wear Time: 3–4 days depending on output volume and seal integrity
Dietit**ian consult** to optimize nutrition to support tissue healing.
Collaborate with the primary physician to ensure adequate pain med for pouch changes.
Follow up with WOC if wear time is less than 24 hours

WOC nursing student Clinical Impression:

Fistula remains high-risk for pouch compromise due to proximity to midline incision and soft backup tissue. Modified pouch approach implemented to improve stability, protect skin, and maintain longer wear time. Will follow and adjust pouching system as tissue contour and drainage patterns evolve.

This section should be only orders, directed by you, the OC nurse. Make sure this is a holistic plan, the above non-highlighted area is task focused. What else needs to be taken into consideration for this patient to find success?

Consider, nutrition, braden sub scores, when to reconsult, pain management, ambulation, comorbidities, any social direction etc.

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

I would advise nursing to anticipate more frequent PRN changes, to avoid delayed response to early undermining or leakage. *Nursing should notify woc immediately to assess the pouching system if there is weakness in the pouching system evidenced by leaking, undermining ect in order to prevent skin breakdown.*

←what would be done if more frequent changes are needed/noted? Make sure you direct this to the caregiver above.

Given the proximity to the incision and the softness of the supporting tissue, I may have considered a convex system to enhance seal security.

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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 learning goal for today's clinical experience was to provide a first-time lesson to a patient on how to change their ostomy pouching system. This goal was not met, as there were no patients available today who required or were appropriate for an ostomy pouch change teaching session.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
My goal will be to become more familiar with the different types of pouching systems.

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-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	✓	

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• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____

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