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: ____10/31/25_____

Number of Clinical Hours Today: __8__ Number of patients seen___**4**_

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

Preceptor: _____Lauren Fomeris_____

Clinical Focus: Wound ____ Ostomy ___x_ 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.**

The first patient I saw was a 60 y.o male with an end ileostomy due to Ulcerative Pancolitis. WOC nurse was consulted d/t c/o peristomal irritations. After taking down his current pouching system, I found that his current pouching system was too small and not enough convexity. The peristomal skin was irritated at 12 o'clock. I remeasured the stoma and recommended a different pouching system, Convatec Convex, which he refused. I did the routine care of the peristomal skin and placed the current pouching system as he requested.

The second patient I saw was a 35 y.o male who is scheduled for an ileostomy 11/3/25 due to Rectal CA with mets. WOC nurse was consulted for site marking. Which I completed and will be going into more detail below.

The third patient I saw was a 70 y.o male who has a loop end ileostomy. WOC nurse was consulted for routine pouch change. I completed that.

The fourth patient I saw was a 68 y.o male who is scheduled for surgery 11/25/25 for an an ileoconduit conduit due to bladder CA. I completed that as well.

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

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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:**

**Braden Risk Assessment Tool**

| | |
|---|---|
| Sensory Perception | |
| Moisture | |
| Activity | |
| Mobility | |
| Nutrition | |
| Friction/Shear | |
| Total | |

WOC nurse was consulted for site marking on a 35-year-old male who will be going to surgery on 11/3/25 for a loop ileostomy due to Rectal CA with mets. He is alert and oriented X 3 with no previous medical history and is not, currently, on any medications. No Braden scale needed as this is an outpatient visit.

Patient was set up to watch an informational approved video about what to expect prior to surgery, during surgery, and after surgery. After patient watched the video, I reviewed what he should expect the stoma to look like. I showed him the pouch that he would see after surgery and ensured him that we would be there to assist and teach him the care of the stoma. I gave him the Ileostomy book and information pamphlets and reviewed his post op diet. I asked him if he had any questions and he said no. I then prepared my equipment for the stoma marking with ink. After washing and drying my hands and donning my gloves, I cleaned his abdomen with alcohol wipes. With him standing, I had him cough and felt the edges of his abdominal rectus muscle. I felt where his rib cage ended, I made a mental note of the right lower quadrant fold, I then had him sit in the chair and then identified a possible site in the right upper quadrant and placed an X. I asked patient if he could see it and he said yes. I made sure the site was approximately 2 finger breaths away from the abd midline and away from the ribs. There were no folds and the site was well supported. I then had him lean forward to see if a fold could be created and it did not. I then had him lie on the bed, I placed one drop of ink on the middle of the X, I took the 25 g needle with a syringe attached for stability and poked him 3 times making a triangle at the junction of where the X met. I then wiped all the excess ink away leaving the tattoo in place. Patient tolerated procedure well. All the pamphlets and book were placed in a bag and given to patient to take home and review. Patient stated he understood and was discharged from home.

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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)**

Post operative, nursing should evaluate stoma site, peristomal area and document color, moisture, and edema.
Nursing staff is to notify WOC nurse if stoma appears dusky, pale, necrotic, and if peristomal site has skin irritations, leakage, or any pouching difficulties.
Nursing staff is to contact dietary to review plan with patient and staff
WOC nurse will follow up postoperatively for patient's initial hands on ostomy care with pouch change

**Describe your thoughts related to the care provided. What would <u>you</u> have done differently**

I felt that the amount of information provided during the preoperative session may have been overwhelming for the patient to absorb all at once. In the future, I would consider scheduling a brief telephone call prior to the in-person visit to review expectations, provide basic education, and allow time for questions. This would help the patient feel more prepared.

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 do stoma marking and see patients with continence issues.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**
My goal is to see patients with continence issues.

**For instructor use only. Do <u>not</u> 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 | ✓ | |

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

Reviewed by: _____ Date: _____

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