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 10/17/25___

Number of Clinical Hours Today: _8_ Number of patients seen___

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

Preceptor: __Sara Weise RN, BSN, WOCN___

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.

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:

Patient with an end ileostomy reports several days of increased moisture to the lower abdomen and perineal area related to pouch leakage. He notes localized tenderness and burning. WOC nurse consulted to assess and manage suspected incontinence-associated dermatitis (IAD). Using adhesive remover wipes, I gently removed the existing pouching system, identified as a Hollister two-piece flat barrier with standard wear. The barrier demonstrated inferior undermining of effluent with partial lifting along the lower edge. The peristomal and adjacent skin were cleansed with warm water and mild soap, rinsed thoroughly with warm water, and dried using 4x4 gauze. Assessment revealed moist erythema consistent with IAD. I remeasured the stoma and peristomal topography. Stoma powder was lightly applied to areas of superficial denudement and excess was brushed

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away. The treated skin was sealed with Cavilon No-Sting Barrier Film and allowed to fully dry.
To improve the seal and correct the inferior skin fold contributing to leakage, I applied a Hollister two-piece convex FlexWear barrier. An Adapt barrier ring was placed and molded at the inferior defect to minimize further undermining. I ensured complete contact and verified that no gaps were present around the barrier.

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)

Clean peristomal and IAD affected skin with warm water and mild soap, rinse, and pat dry.
Apply stomal power to moist erythematous areas.
Seal with Cavilon No Sting Barrier Filma and allow to dry completely.
Apply Hollister 2 piece convex FlexWear barrier for all pouching changes.
Place Adapt Barrier ring to full contour irregularities.
Empty pouch when it is a 1/3 -1/2 full
Inspect peristomal skin every shift.
Reposition every 2 hours to prevent dependent moisture
Notify WOC nurse for any concerns.
Woc nurse will reassess in 2-3 days or sooner if IAD becomes worse or there is leakage.

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

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

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

Reviewed by: _____ Date: _____

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