Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: **Selena Perez** Day/Date: **12-4-25**

Number of Clinical Hours Today: **8** Number of patients seen **6**

Care Setting: Hospital **X** Ambulatory Care ____ Home Care ____ Other ___

Preceptor: **Tammy Swegles**

Clinical Focus: Wound ____ Ostomy **X** Continence ____

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

Tammy and I were able to see six patients today! The first five were seen in the morning down in the ED as there were many new consults overnight.

The first patient was here for a fall and resulting trauma, however had an existing DFU on the right plantar foot.

The second patient was here for ascites and general malaise, presenting with scattered wounds on the lower extremities and hx of severe PAD.

The third patient is one I have seen some months ago on a previous admit, back with a leaky J-tube. Prior to admission, the surgeons wanted to increase the size of the J-tube (similar to the last clinical situation…).

The fourth patient was an individual with paraplegia, a newly developed coccygeal wound, and an incidental find of a worsening old dehisced back incision from August. At first glance, it appears it could benefit from NPWT however the patient has chondrosarcoma with mets to the spine (reason for spinal surgery) and will need a further clinical picture (i.e. CT, cultures). For now, we ordered moistened-gauze roll packing, secured with an ABD, to be changed twice daily.

The fifth patient was an individual who presented with dry gangrene of the left great toe, hx of severe CAD and PVD.

Ok!

Chart note:

Assessment
59 y.o. male
Dx: Rectal adenocarcinoma
Hx: Rectal adenocarcinoma, cholecystectomy, hyperlipidemia
S/s: N/a - Planned procedure

Ostomy team follow up for new loop ileostomy, POD#2. Patient was seen yesterday by the ostomy team and provided informational ileostomy folder and initial education with the goal of emptying their own pouch independently before the next visit. At this time patient sitting in chair, agreeable to education and pouch change today. Patient has been reviewing the provided ostomy booklet as well as emptied his pouch independently 5-6 times. Patient is ambulating independently in the room and hallway, tolerating full liquid diet, and says his pain is controlled. Ostomy appliance was changed this visit, accessories discussed, and supplier chosen.

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RUQ ileostomy: Stoma is moist, pink, and protruding above skin level with single bridge in place vertically. Output is thin dark brown. Peristomal skin blistering noted along the borders of the barrier once removed, otherwise skin is intact.

Ostomy education reviewed:
-Pouch systems: flat 2 piece (currently)
-Barrier types: flat (currently)
-Accessories: Belt, stoma powder, barrier rings, barrier extenders
-Pouch emptying frequency: when 1/3-1/2 full
-Pouch emptying procedure: patient is emptying pouch independently
-Showering with or without pouch
-Resume normal activity over 6-8 weeks
-Appliance change frequency: q3-5 days
-Appliance change procedure: patient assisted with measuring stoma and cutting to fit
-Healthy stoma: moist, pink, rosebud-like with intact mucocutaneous junction
-Potential ileostomy complications and s/s: food bolus or obstruction, dehydration, peristomal hernia
-Proper nutrition, electrolyte replacement, and hydration status
-SecureStart: patient would like to be contacted by this phone number: ~~517.315.9947~~ ← *please no patient identifiers in journals!*
-Patient declined Coloplast Care program
-Supplier chosen: HFJ DME
-Discussed visiting nurse, patient would like to research further about cost
-Ostomy supplies provided to practice and explore

Recommendations
Change 2 piece 2 ¾" appliance q3-5d and PRN

- Remove old appliance, note status of seal
- Cleanse peristomal skin gently with water, pat dry
- Measure stoma, cut flange to fit stoma
- Apply 2 ¾" flange with stoma paste\
- Secure drainable pouch to flange, secure closure

Order additional supplies by contacting warehouse DA (Flange 2 3/4" #11204; Pouch 2 3/4" #18194)

Tentative Rx:
-Hollister Cut to Fit CeraPlus Skin Barrier 2 ¾" #11204 -4 boxes of 5
-Hollister Drainable Pouch Lock N Roll Closure with Filter 2 ¾" #18194 -2 boxes of 10
-Adapt Skin Protectant Wipes #7917 -1 box of 50
-Adapt Adhesive Remover Wipes #7760 -1 box of 50
-Adapt Ostomy Appliance Belt #7300 -2 belts
-Adapt Stoma Powder #7906 -2 bottles
-Adapt Skin Barrier Paste #79300 -2 tubes
-Adapt Barrier Extenders #79402 -1 box of 30

Patient was very engaged throughout follow up. He describes himself as a troubleshooter so mental and emotional preparation was discussed as well as strategic planning to make adjusting to his life as an ostomate as smooth as possible. Ostomy.org was recommended to patient as a resource. Patient signed up for the Hollister SecureStart

Program under the above phone number. Referral placed for HFJ DME. Encouraged the patient to continue practicing both pouch emptying but appliance change as well. Ostomy team will continue to follow along as scheduling allows, please reach out with any questions or concerns.

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	3
Activity	4
Mobility	4
Nutrition	4
Friction/Shear	3
Total	**22**

WOC Plan of Care (include specific products)

- Change 2 piece 2 ¾" appliance q3-5d and PRN
  - Remove old appliance, note status of seal
  - Cleanse peristomal skin gently with water, pat dry
  - Measure stoma, cut flange to fit stoma
  - Apply 2 ¾" flange with stoma paste
  - Secure drainable pouch to flange, secure closure
- Encourage patient to adequately hydrate with fluids and electrolytes ←*operationalize this. What is "adequate?"*
  - Q4 I/O's, assess ileostomy effluent ←*what are reportable parameters? This patient has high risk*
  - Monitor and document signs of dehydration or obstruction ←*and then?*
  - Monitor and document signs of urine retention or oliguria (hx) ←*intervention?*
- Encourage consumption of majority/all of balanced meals, supplement with high-protein snacks
- Pain/discomfort management
  - Medicate as ordered and needed
- Encourage activity as tolerated, no lifting >10lb
- *Consider further consults*
- *Make sure to continue ambulation*

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

I really had a great experience with my patient and this follow up. The patient was incredibly receptive and asked many questions, some that also triggered me to ask my own questions. I think creating a basic plan with topics to cover and important questions to ask the patient, and then making it into a little card may help me remember to cover everything! My preceptor helped cover the areas I had missed thankfully. ←*a "cheat sheet" is something I used quite often in my own time providing education to patients at the bedside – it's a good framework, just make sure you individualize plans.*

Goals

What was your goal for the day?

My goal for today was… see a wound type I've never seen before! I did not meet this goal HOWEVER I have identified a need for better tube stabilization and management at our facility. *ok*

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What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
My learning goal for next clinical day is to experience more use of topical agents when managing wounds (e.g. santyl, Dakins, acetic acid).

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	See comments	
● 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	✔	

Hi Selena – see my comments throughout this journal. Make sure to operationalize directives and to have associated actions with all directed assessment. Make sure to apply this to your future submissions. Reminder- Your last two submissions for ostomy need to include an ostomy marking patient, if able. Reach out with any further questions. -Mike

Reviewed by: ____Mike Klements 12/8/25 received_____ Date: ___12/11/25_____

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