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: Friday 10/10/25

Number of Clinical Hours Today: 8 Number of patients seen **4**

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

Preceptor: Jeanie Osby

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.

10/10/25 We saw 4 patients.

First patient had an end ileo conduit s/p bladder ca day #1. WOC was consulted for patient's first pouch change.

The second patient had a decrease in stoma output. He had a loop transverse colostomy. WOC was consulted to do a colostomy stimulation.

The third patient had a substernal wound vac. The WOC was consulted to do a dressing change.

The fourth patient had a loop end ileal conduit. The WOC was consulted to remove the rod and foley and do 1st teaching.

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:

75 y.o patient A & O X 3 s/p radical cystectomy with urinary diversion (orthotopic neobladder) presents with continuous urinary incontinence, resulting in moisture exposure to perineal skin. Referred to WOC nursing for evaluation of incontinence-associated dermatitis (IAD), selection of an external urinary containment device, and development of a continence management plan. Patient reports anxiety related to leakage, odor, and skin irritation. Denies dysuria or suprapubic pain. Patient is unable to voluntarily control urine flow. Peri area with mild erythema but no open areas. Urine clear yellow and no foul odor. Patient denies pain but c/o mild discomfort and burning. Patient is ambulatory with assistance.

Medications

Acetaminophen 650 mg PO q6h PRN
Tamsulosin 0.4 mg PO daily
Docusate sodium 100 mg PO BID
Enoxaparin 40 mg SQ daily

Braden Scale

Sensory Perception: 4
Moisture: 2
Activity: 3
Mobility: 3
Nutrition: 3
Friction/Shear: 3
Total Score: 18

Patient and bedside nurse present. Education provided using verbal instruction and demonstration. Patient engaged and asked appropriate questions.
Perineal area cleaned with warm water and gently patted dry.
Applied moisture barrier cream to affected areas for treatment and prevention of IAD.
A condom catheter external male urinary containment device placed to manage continuous incontinence and reduce skin moisture exposure.
Secured device per manufacturer guidelines; connected to bedside drainage bag ensuring unobstructed flow.
Implemented timed toileting schedule every 2 hours while awake as tolerated.
Provided patient education on:

Cause of urinary incontinence
Proper use and care of external urinary device
Importance of daily skin inspection
Prompt cleansing after episodes of moisture
Hydration to maintain urine dilution

Reinforced need to avoid absorbent briefs in bed to reduce moisture trapping.
Patient tolerated skin care and device application without complication. External containment device

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remained intact with no leakage noted during visit. Patient verbalized understanding of device use and skin care regimen. Anxiety decreased by end of session. Perineal skin protected with no further moisture exposure observed.

Plan

Continue external urinary containment device with daily skin assessment.
Maintain moisture barrier application with each episode of incontinence.
Continue timed toileting schedule.
Monitor for worsening IAD or skin breakdown.
WOC nurse to reassess as needed or if skin integrity declines.

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)

Plan:

Clean perineal and genital area with warm water after each incontinence episode.
Gently pat skin dry.
Apply moisture barrier cream to perineal area twice daily and after each incontinence episode.
Assess and document perineal skin changes each shift.
Notify provider and woc nurse for worsening erythema, pain, and open areas.
Continue condom catheter to help manage incontinence and to minimize skin moisture.
Empty drainage bag when ½ full and maintain dependent drainage.
Monitor penis for signs of edema and pain.
Implement timed voiding every 2 hours while awake to reduce leakage.

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

Referral for pelvic floor physical therapy

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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

Manage incontinence using an external device. I think the goal was met.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) **Identify continence issues and address appropriately.**

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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