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 ____ 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.**

During this clinical day, I was hands with the woc nurse with care of multiple patients requiring advanced ostomy and wound management:
We evaluated a patient, along with one other woc nurse, 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 woc nurse, assessed and managed a leaking enterocutaneous fistula pouch. Dressing and pouching strategies were discussed 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.

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

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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:** woc nurse consulted for leaking fistula pouch

**History:**
woc nurse 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 and fecal incontinence of liquid effluent. 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

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- 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)**

Remove existing pouch weekly and as needed for leakage, loosening, odor, or patient discomfort.

Cleanse perifistular skin gently with warm water only; avoid soap, wipes, or cleansers that leave residue. Pat skin completely dry.

Assess perifistular skin at each pouch change for erythema, maceration, denudement, or undermining and report any changes to the WOC nurse promptly.

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Apply Stomahesive half-sheet wedge inferior to the fistula to support loose, mobile abdominal tissue.

Place Hollihesive wedges circumferentially using an overlapping technique to correct contour irregularities and improve wafer seal.

Position bow-tie–shaped Hollihesive wedge between drain sites to provide additional support and prevent undermining.

Apply Stomahesive paste as caulking to fill creases and seal junctions between wedges and wafer; do not use paste as the primary adhesive.

Apply Coloplast flat postoperative pouch with viewing window, ensuring the opening is centered over the fistula.

Apply a thin smear of Stomahesive paste beneath the wafer opening to enhance seal integrity.

Reinforce wafer edges using Mefix tape framing technique to improve wear time and reduce edge lifting.

Maintain continuous connection of pouch to gravity drainage system to minimize pouch weight and reduce risk of seal disruption.

Empty drainage bag when one-third to one-half full and document output volume and consistency each shift.

Maintain a leak-free pouching system at all times; treat leakage as urgent.

If leakage occurs, remove the pouch immediately and repeat the full pouching procedure; do not patch or reinforce a leaking system.

Do not apply powders, creams, or ointments beneath the wafer unless specifically directed by the WOC nurse.

Ensure the surrounding abdominal wound and fistula effluent remain completely separated at all times.

Notify the WOC nurse for signs of infection including increased drainage, foul odor, warmth, pain, or erythema.

Maintain continuous gravity drainage to prevent uncontrolled effluent release and reduce continence-related skin exposure.

In the event of pouch failure or drainage disconnection with stool exposure, cleanse affected skin immediately using warm water and apply a zinc oxide–based moisture barrier ointment to the perineum, buttocks, and groin as needed.

Implement continence checks every two hours and as needed during periods of high output.

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Position the patient to avoid tension on the pouching system, avoiding excessive twisting, pulling, or abdominal strain.

Collaborate with the provider and dietitian regarding stool consistency management, including antidiarrheals or fiber modification, as ordered.

Document all leakage events, skin changes, output characteristics, and continence-related episodes in nursing documentation.

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

I would advise nursing to anticipate more frequent PRN changes, to avoid delayed response to early undermining or leakage. ←*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.

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 <u>not</u> remove or edit:**

| CRITICAL ELEMENTS | Completed | Missing |
|---|---|---|

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| | | |
|---|---|---|
| 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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