Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: _Arsenic T. Manlangit_____ Day/Date: Monday, 1/5/2026

Number of Clinical Hours Today: _8___ Number of patients seen__**6**__

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

Preceptor: Lauren Forneris, RN, CWOCN and Chizu Sakai-Imoto, RN, CWOCN

Clinical Focus: Wound ____ Ostomy __X__ Continence ____

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.

Today I was at the Colorectal Surgery Clinic. I was able to observe stoma site marking. Also, there was a patient who came in with an established stoma who came in because she wants a certain pouch and was requesting assistance with reaching out to a DME company. The team also received a page regarding a patient who is for extubation of a K pouch. Another patient came in the afternoon for a follow up of his ileal conduit and is asking for review of prescription for his stoma supplies.

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:

45 year old male with past medical history of sleep apnea (on CPAP), migraine with aura, GAD, ulcertative colitis, coronary spasm, NSTEMI s/p heart cath in 2017, portal vein thrombosis, laparoscopi total abdominal colectomy and end ileostomy in 10/2021, open completion proctectomy with Koch pouch in 03/2022. He developed a peristomal hernia and had difficulty intubating his K pouch so he had a parastomal hernia repair with K Pouch reciting on 12/8/25.

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The patient presented to the clinic with a constant drainage system. The ET WOC Nurse irrigated the K Pouch with 60 mL of warm tap water prior to extubation. A brown thin liquid effluent was noted. The WOC Nurse then removed the constant drainage system with no complications. No leakage was observed after extubation. A 30 Fr Marlen Curved catheter was then used by the patient to intubate the stoma and irrigated with 60 mL of warm tap water. A brown thin liquid effluent was noted. No complications were noted.

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)

- You may need to drain the pouch every 2-3 hours. The goal is draining the pouch with decreasing frequency over the next few months to increase the pouch capacity until you are down to between two and four times per day.
- Properly clean and rinse the Marlen catheter after each use with soap and water.
- You may irrigate the pouch with 60 mL of warm tap water in case any undigested foods block the catheter. If you feel any bloating or distention, you should drain the pouch. Empty the pouch before engaging in physical activity and before bed.
- Continue to monitor your stoma. Cleanse the skin around the stoma with nonoily soap and water and patted dry as needed.
- You may cover the stoma with a dry gauze dressing or stoma cap.
- You may advance your diet to soft diet as advised by your Surgeon. Begin to eat low-fiber foods and may add a different variety of food one at a time.
- You have mentioned that you can tolerate lettuce in the past with no issues with blockage. Just make sure to chew your food very thoroughly as the waste will need to come through the drainage catheter.
- It is best to avoid foods such as sweet corn, mushrooms, skins and peels, nuts, etc., as these can block the catheter and make it difficult to drain.
- Drink grape or prune juice to keep the stool thin enough to drain easily.
- No heavy lifting more than 10 lbs as instructed by your Surgeon.
- Follow up with your surgeon in 3 months.

Reference

Rubin, M. (2022). Surgical management of Crohn's disease and ulcerative colitis. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.). *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 71-99). Wolters Kluwer.

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

The patient is aware and knowledgeable of managing the continent ileostomy. He is also aware of his dietary restrictions. The patient can be provided with teaching materials to help provide further resources should there be any questions and concerns that may arise such as those found in UOAA website (e.g., https://www.ostomy.org/wp-content/uploads/2024/04/UOAA-New-Ostomy-Patient-Guide-2024-04.pdf).

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 this day is to be able to perform stoma assessment.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
My goal for tomorrow is to perform stoma care.

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	✓	

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• 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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