Cleveland Clinic

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

**Daily Journal Entry with Chart Note & Plan of Care**

Student Name: Brittany Sluiter  Day/Date: Tuesday/January 6, 2026

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

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

Preceptor: Given, Ashley & Cisnero, Cynthia

Clinical Focus: Wound ____ Ostomy ____ 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.**

During this practicum day, I encountered a diverse group of patients requiring specialized wound, ostomy, and continence nursing care across multiple care settings including inpatient hospital units and the ED. The patients represented a wide range of clinical complexities, diagnoses, and levels of independence, allowing me to apply and expand my WOC knowledge in real-time clinical situations.

Several patients had complex ostomies related to Crohn's disease, including individuals with recent total colectomies, ileostomy revisions, mucocutaneous separation, peristomal hernias, and significant moisture-associated skin damage. These encounters emphasized the importance of understanding surgical history, anatomical considerations in stoma placement, and the impact of moisture, output volume, and nutrition on peristomal skin integrity. I participated in ostomy appliance assessments, product selection (including going to CENTRAL SUPPLY to obtain supplies; this all requires documentation and recording), barrier ring use, moisture control strategies, and patient education using teach-back methodology.

I also cared for a patient with neurogenic bladder and severe mobility impairments, including a quadriplegic patient requiring suprapubic catheter exchange. This encounter allowed me to assist with sterile suprapubic catheter change and reinforced the importance of catheter stabilization, infection prevention, moisture management, and proactive pressure injury prevention. Comprehensive skin assessments identified fungal involvement, early skin breakdown, and pressure injury risk, leading to timely initiation of specialty beds, offloading devices, and topical treatments. This experience reinforced my role as a patient advocate and highlighted the need for early nurse-driven interventions rather than reactive care.

Another encounter occurred in the ED, where I assisted with the management of a peristomal skin injury complicated by anticoagulation therapy. Providing WOC care in a nontraditional environment, such as a hallway bed, required adaptability while maintaining best practices for hemostasis, skin protection, patient

education and integrity/privacy (let's just say, we had to get creative to achieve this!). This experience reinforced the importance of individualized care planning and patient education, particularly regarding nutrition, hydration, and factors that influence wound healing.

In addition to direct patient care, I engaged in interdisciplinary collaboration and notes, including communication with bedside nurses, physicians, and dieticians. I observed how WOC nurses function as consultants, educators, and system-level problem solvers. I also participated in reviewing lab trends, surgical progress photos, and care plans which strengthened my ability to synthesize clinical data and apply it to patient-centered interventions.

Overall, these encounters enhanced my clinical reasoning, reinforced evidence-based WOC practices, and deepened my appreciation for the preventative role of WOC nursing. This practicum experience strengthened my confidence in ostomy management, skin and wound assessment, patient education, and advocacy while highlighting the critical importance of proactive, interdisciplinary, and holistic care in improving patient outcomes.

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 female with a history of quadriplegia and neurogenic bladder seen for suprapubic catheter exchange due to a contaminated UA and concerns for leakage and skin integrity. The patient is blind but alert and oriented x 3 (disoriented to time of day only) and able to verbally advocate for herself. Patient was able to tell us about her care at home, her current problems with recurrent UTI, and discuss her past medical history-all which correlated to medical team's notes. She was very pleasant, calm, cooperative, and stated to us, "2026, I turn 46 and it's going to be a great year. I want to get better."

Pertinent past medical history includes quadriplegia, obesity, neurogenic bladder, type 2 DM, hypertension, and chronic neuropathic pain/spasticity. Current medications include Insulin lispro sliding scale four times a day with meals and before bedtime, Gabapentin 300mg PO three times daily, Baclofen 10mg PO three times daily, Oxybutynin 5mg PO twice daily, Lisinopril 10mg PO daily, Robaxin 750mg PO every 8 hours PRN muscle spasms, and Tylenol 650mg PO every 6 hours PRN pain or temperature >100.4.

Laboratory review revealed elevated WBC of 13.5 and UA contaminated with mixed flora; plan to recollect urine sample following catheter exchange. All other labs were within normal limits.

Assessment revealed a malodorous suprapubic catheter site with urine leakage around insertion site, which was noted to be in between the patient's lower abdominal skin fold. The catheter site was not stabilized prior to WOC involvement. 375mLs of urine was emptied from the urine drainage bag. Urine noted to be yellow, extremely concentrated, hazy, malodorous, and contained particulate sediment; the drainage bag was purple-stained, suggestive of bacterial colonization. The patient required an 18 French suprapubic catheter. Skin assessment revealed moderate moisture exposure with a fungal-appearing rash to the perineum and posterior thighs and buttocks, as well as two new superficial perineal skin tears with mild bleeding. The patient had flaccid bilateral lower extremities with severe foot drop, bilateral heels noted to be clean and dry; right upper extremity strength was 5/5, and the patient was able to assist minimally with turning. No offloading boots or specialty bed were in place at the time of assessment. Multiple healed chronic wounds were noted to be at high risk for reopening due to moisture and immobility, specifically an area down the midline of the intergluteal cleft, under bilateral breasts, and bilateral abdominal skin folds.

Using sterile technique, the WOC nurse performed a suprapubic catheter exchange with assistance. The catheter balloon was inflated with per current device specifications. However, an extra 5mL was added due to leakage per the WOC nurse's expert discretion; the catheter was stabilized via STAT-LOCK to reduce traction and leakage. 10mL of clear, yellow urine return was noted status-post catheter exchange. Drainage bag was labeled with date/time/WOCN initials. Barrier zinc cream was applied to perineum, posterior thighs, and skin folds. Fungal involvement was identified, and nystatin topical cream therapy was ordered. The two new perineal skin tears were gently cleansed with normal saline, and a silicone moisture barrier was applied for protection. Off-loading boots were initiated bilaterally, and a specialty pressure redistribution bed was ordered. The WOC nurse provided education to the patient and bedside nurse regarding catheter stabilization, moisture management, and pressure injury prevention. All new findings and interventions were discussed. The patient verbalized understanding and demonstrated strong self-advocacy despite visual impairment.

**Braden Risk Assessment Tool**

| | |
|---|---|
| Sensory Perception | 2 |
| Moisture | 1 |
| Activity | 1 |
| Mobility | 2 |
| Nutrition | 1 |
| Friction/Shear | 1 |
| Total | 9 (High Risk) |

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)**

-Always maintain suprapubic catheter with secure stabilization device (STAT-LOCK)
-Assess suprapubic catheter site every shift for leakage, erythema, odor, or signs of infection
-Empty drainage bag routinely; monitor urine color, clarity, sediment, and odor
-Recollect urinalysis following catheter exchange using sterile technique per policy guidelines
-Cleanse perineal and posterior thigh skin with pH-balanced wound cleanser after each incontinent episode

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-Apply zinc-based barrier cream to perineum, posterior thighs, and abdominal folds twice daily and as needed
-Apply nystatin cream to fungal-appearing areas as ordered
-Assess perineal skin tears every shift and with incontinent episodes; maintain clean, dry, environment to promote healing
-Assist patient to reposition patient every 2 hours or as patient requests
-Maintain specialty pressure redistribution mattress
-Maintain off-loading boots bilaterally
-Reinforce patient and caregiver education regarding catheter care, stabilization, and skin protection
-Notify provider of worsening leakage, persistent skin breakdown, or signs of infection
-Collaborate with urology if leakage persists despite stabilization and local skin management

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

This encounter reinforced the importance of appropriate catheter and device selection in managing suprapubic catheter leakage. During the visit, the catheter balloon was inflated beyond manufacturer-recommended volume to reduce leakage. In retrospect, I would have considered using a suprapubic catheter with a larger balloon capacity rather than overinflating a smaller balloon. Additionally, instead of relying solely on fenestrated gauze to manage leakage, I would have trialed a pouching or urine collection device around the suprapubic site to better contain output, protect the skin, and allow for accurate measurement of urine leakage. This information could then be communicated to urology if leakage persisted, supporting timely escalation of care.

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?**
To gain hands-on experience assisting with a suprapubic catheter exchange and to perform a comprehensive skin and pressure injury risk assessment in a high-risk patient.
**Was it met? Why or why not?**
Yes. I assisted with the catheter exchange, participated in identifying skin and pressure injury risks, and collaborated on initiating preventative interventions.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**
To further develop clinical decision-making related to continence management especially in unique cases including device selection, topical therapies, and containment strategies for patients with persistent leakage and at high risk for skin breakdown.

**For instructor use only. Do <u>not</u> 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 | | |

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| | | |
|---|---|---|
| • 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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