Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Amanda Peters Day/Date: January 6, 2026

Number of Clinical Hours Today: 10 Number of patients seen 7

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

Preceptor: Pai-Yun Krug, 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.

I saw 7 patients with my preceptor today. Each patient took about an hour. We saw a patient with a consultation to initiate compression therapy. The ABI results were not able to be obtained due to the patient's posterior tibialis pulses not disappearing with bf cuff inflation after multiple attempts to obtain a systolic pressure in bilateral legs. The patient was also having some pain in his RLE. The hospitalist was notified, and vascular consult and arterial doppler with ABI was put in by the physician. The patient will need to be re-evaluated for compression once consult and testing is performed. Next, we followed up on one of my preceptor's patients with an history of spinal cord infarct, existing end colostomy due to a prior history of colovesical fistula from a year ago and existing stage 4 pressure injury. He came to the hospital for suspected osteomyelitis to the sacrum, sent by his wound care doctor at an outlying wound care clinic. The wound care clinic stopped his negative pressure wound therapy prior to admission, so we used Aquacel Ag to lightly pack the wound and secured with Mepilex silicone foam border dressing 6x6. The patient had a tunnel at 8 o'clock in the wound bed that was 3.4 cm deep, and bone could be felt. Regarding his end colostomy, the patient's wife performs his ostomy care. He has a retracted 33 cm oval-shaped stoma and needs convexity to allow stoma budding. The patient's wife reported during Pai-Yun's last visit that the patient occasionally develops a blister around 1 o'clock in the peristomal skin at home; it was suspected to be from tension and possibly from the rigid flange, and the pouch he was previously using (Hollister New Image Cera-plus Skin barrier convex 70mm flange and Hollister New Image Drainable pouch Lock 'n Roll closure 70 mm flange) was changed to Coloplast Sensura Mio flex 2 piece flex soft convex light drainable pouch due to his firm abdominal contour. The wife reported she liked this pouch and the patient states he had no leaking issues. The backing of the wafer was not saturated after a 4-day wear, as the patient usually has formed stool output. We educated the wife on how to apply the pouch this visit, and she assisted and was able to obtain a good seal. She will be attempting pouching herself with this pouch again in 4 days before she makes decision to request a change in supplies. Next, we saw a patient with a stage 3 pressure injury to the left heel that was present on arrival; the patient was recently discharged and readmitted for respiratory issues. The wound had developed some

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erythema to the peri-wound compared to last admission. We cleansed and irrigated the wound with Anasept, put a Mepilex Ag 4x4 onto the wound, applied Heel-Medix advanced heel protectors, and got an Immerse low air loss mattress ordered. We saw a patient with MASD to the gluteal cleft; the patient had Polymem foam dressings and abdominal pads taped over their rectum upon assessment. This was removed and Cavilion liquid skin protectant and triad wound dressing cream was used to the area. We then saw a patient with an end colostomy and an end ileostomy, in which I will discuss further. We also saw a consult for an existing ostomy of a patient with an end colostomy and chronic peristomal hernia. The patient was not experiencing any peristomal skin issues. The stoma measured about 40 mm when lying flat and 48 mm when in sitting position. The patient is not ambulatory and the patient's son performs ostomy care at home. The hospital did not carry the pouch she was using, so we temporarily placed a Hollister Premier 1 piece cut to fit flat Flexend drainable appliance cut to accommodate the maximum stoma measurement obtained (48 mm) and achieved seal. We saw another patient for a consult for open to the gluteal cleft and buttocks; the bedside nurses had initiated zinc oxide barrier cream two days ago. Upon our assessment today, the denuded skin was smaller and more superficial compared to wound pictures taken upon admission, and the gluteal cleft was dry. It is suspected the moisture was from sweat and urinary incontinence, and the urine has been contained with an external PrimoFit urinary device while in the hospital. Lastly, we followed up my preceptor's patient in the ICU with skin failure to the sacrum, and we noticed the wound is overall getting smaller in appearance and the patient has been extubated again.
We discussed some Coloplast, Convatec, and Hollister products. We also discussed some different types of convexity wafers.
Types of patients: ABI attempt with vascular consult and arterial doppler initiated by physician, existing end colostomy and stage four pressure injury, stage 3 pressure injury left heel, MASD to gluteal cleft from urinary incontinence and perspiration x2, end ileostomy and end colostomy (same patient), skin failure sacral wound follow up

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.

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Chart note:

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	3
Total	20

WBC: 7.9
HGB: 9.0
SODIUM:132
POTASSIUM:4.8
BUN: 27
CREATININE: 1.44
GFR:49
MAGNESIUM: 1.7
PHOSPHORUS: 4.1
CALCIUM: 8.8

Meds: NS IV infusion continuous at 75ml/hr

-Patient with past medical history of h/o colon adenocarcinoma, s/p sigmoid colon resection and end colostomy 8 months ago, on chemotherapy/FOLFOX that is currently on hold, s/p small bowel resection with end ileostomy creation last admission in early December after a small bowel obstruction and perforation was found. The patient also has a non-functional end colostomy to the LLQ from previous surgery in early 2025. Patient readmitted for fall and possible syncopal episode this admission and the patient's cardiology consult is pending. The patient lives at home with his wife and reports he performs his own ostomy care. Patient reports he feels much better today than yesterday. He reports that he estimates that he was having 1-2L of output from his ileostomy at home, but was not formally measuring output after previous discharge. He states he empties the pouch multiple times a day. He reports he has been following the dietician's instructions and recommendations of food choices for his new ileostomy at home from previous admission. He reports he has been drinking Pedialyte at home. He does report some irritation to his peristomal skin. He had to change his ostomy appliance last night while admitted due to leakage. The patient currently has two stoma sites; he reports he was told by his surgeon that no other plans for additional surgery will occur until after chemotherapy treatment. He reports he is using a closed end pouching system to his LLQ nonfunctional stoma. He is using Convatec Esteem one-piece moldable drainable pouch

at home for his RLQ end ileostomy.
- Patient is alert and oriented, able to follow commands; resting in chair, call light and personal items within reach. Patient moved back to bed for ostomy assessment with minimal assistance. Patient agreeable to assessment of both ostomy sites.
RLQ end ileostomy- Upon initial assessment, peristomal skin was seen through pouch. Emptied 25 ml of pasty brown stool from appliance. Removed 2-piece Convatec Natura Durahesive moldable drainable appliance with 57mm flange that was given to patient by nursing staff as patient currently does not have his supplies. The backing of skin barrier was minimally eroded. The stoma opening of the skin barrier was fully molded to maximum amount (45 mm). The stoma is budded, red, moist. The peristomal skin presents with peri-stomal moisture associated skin damage related to stool exposure with superficial, denuded, pink open areas circumferential around stoma. Asked patient was he has been using on his peri-stomal skin. He reports he was using warm water to clean with gauze, patting dry, and applying the pouch. Patient is agreeable to teaching demonstration. Patient cleansed the peristomal skin with water and gauze and patted dry. Educated and demonstrated to patient on how to “crust” denuded areas with Convatec stomahesive protective powder, dust off the excess, and seal with Cavilon liquid skin protectant to create a surface to put pouching system on. Repeated crusting technique for patient to observe. Patient verbalized understanding. Patient measured stoma at about 33 mm with stoma measuring tool. Educated patient to ensure skin barrier is protecting as much of the peristomal skin as possible, as the denuded areas are from stool leaking onto the skin and causing irritation. Patient verbalized understanding. Applied Eakin ring to peristomal skin to assist with seal around stoma. He reports he has these at home. Molded skin barrier of Convatec Esteem one-piece moldable drainable pouch and applied to patient’s skin. Applied drainable pouch to skin barrier and achieved seal.
-LLE end colostomy- Removed previous closed end pouch with no skin barrier wear noted. Stoma is pink, flush to skin, round in shape, moist, and 20 mm in size. The mucocutaneous junction is intact with sutures in place. Peri-stomal skin clean, dry, and intact. There is no stool or flatus in previous appliance. He admits to not changing this appliance for 2 weeks, as the stoma has not been having output. Educated patient to continue to change appliance weekly to assess appearance of stoma and peri-stomal skin. He verbalized understanding. Patient asking if there is a smaller appliance he can use to cover the stoma as he is not having output from this stoma site. Showed patient what a stoma cap looks like, and he reports he would like to try these. Unfortunately, the hospital only carries Coloplast stoma caps at this time, and he reports he has had a history of skin reactions to Coloplast products. Patient cleansed peristomal skin with water and patted dry with gauze. He successfully applied Cavilon liquid skin protectant spray to peristomal skin. Cut to fit 20mm stoma and applied

Hollister Pouchkins one-piece flat wear cut-to-fit transparent appliance for temporary use until Convatec stoma cap can be ordered, will notify CM of new supply need.
-Midline incision with staples in place and are intact. Acute incision appears to be healed and scarring. The patient is about 4 post-operative. The patient reports he has been unable to see general surgeon for follow up due to office being backed up after the holidays; he states he has an appointment in 10 days. Will notify hospitalist to see if consultation to general surgeon is appropriate for staple removal while patient is in hospital of his midline incision and assessment of the patient's end ileostomy site.
-Educated patient on importance of measuring ileostomy stoma output upon discharge as the colon is being bypassed with ileostomy creation and he is at risk for recurrent dehydration. Notified goal is below 1200 ml of output in a 24-hour period. Instructed to notify surgeon if ostomy output is over 1500 ml in a 24-hour period. Educated patient on signs and symptoms of dehydration including increased thirst, decreased urinary output, dizziness, lethargy. Educated the patient on foods that may bulk liquid stool including bananas, applesauce, and toast. He verbalized understanding. Patient with dietician consult in place and pending. Patient given 2 measuring cannisters to take home. Patient also given extra ostomy supplies for both stomas and left at bedside. All questions answered. Patient has home health visits two times a week for continued ostomy education upon discharge per CM note.
-Patient is continent of urine and uses his call bell for assistance to the bathroom.
-Patient has no open wounds at this time.
-Discussed with primary RN of need to begin documenting stool output and urinary output for correct documentation of intake and output.

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)

Ostomy care
RLQ end ileostomy 33mm stoma size, oval shape: Please assist patient with ostomy care as needed; encourage patient to assist with appliance change; change appliance immediately for leakage of stool or compromised seal; otherwise change appliance every 3-4 days.
-Empty appliance when 1/3 full and prior to ostomy appliance changes

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-Measure output from ostomy and document under I&O
-Remove ostomy appliance with Sensi-care adhesive releaser and the push-pull method
-Cleanse peristomal skin gently with warm water and gauze
-Pat peri-stomal skin dry
-"Crust" open irritated peristomal skin if needed with Convatec stomahesive powder, dust off excess
-Apply Cavilon no sting barrier spray to peristomal skin and allow to dry for 10 or more seconds
-Mold ConvaTec Eakin cohesive ring to fit around stoma
-Apply Eakin ring to peri-stomal skin
-Separate ConvaTec Esteem 30-44mm moldable skin barrier and drainable pouch- ref #413516
-Remove tab #1 from skin barrier and mold to fit around stoma size, 33mm and oval shape
-Remove tab #2 from skin barrier and apply this side to patient's skin with light pressure to ensure seal
-Remove tab #3 from skin barrier
-Remove backing tab of drainable pouch and apply this side to tab #3 on skin barrier
-Close tail end of drainable pouch by folding three times and clicking seals together
-If needed, have patient apply hand over appliance gently for 3-5 minutes to enhance seal.
-Patient may need to limit activity for 10 minutes after applying new pouch

LLE end colostomy 20 mm stoma size, oval flush shape: Please assist patient with ostomy care as needed; encourage patient to assist with appliance change; change appliance immediately with leakage of stool or compromised seal; otherwise change appliance weekly.
-Remove ostomy appliance with Sensi-care adhesive releaser and the push-pull method
-Cleanse peristomal skin gently with warm water and gauze
-Pat peri-stomal skin dry
-Apply Cavilon no sting barrier spray to peristomal skin and allow to dry for 10 or more seconds
-Cut to fit skin barrier to stoma size (20 mm, round shape)
-Remove white backing from skin barrier and apply to patient's skin
-Close tail end of drainable pouch by folding three times and clicking seals together
-If needed, have patient apply hand over appliance gently for 3-5 minutes to enhance seal.
-Patient may need to limit activity for 10 minutes after applying new pouch

-**Midline incision with staples:** May leave open to air at this time; general surgery consult is pending for evaluation of incision

-Measure urinary output and ostomy output for appropriate I&O

-Call or reconsult as needed for questions or concerns

New supplies needed for discharge *patient has 2 stomas*:
-Active-life one piece stoma cap cut-to-fit reference #756611

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

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If time persisted, I would have reviewed the patient's medications to see if patient was placed on any antimotility agents. The patient is being worked up for a possible cardiac syncopal episode and does have a history heart failure and stage 3 kidney disease; however the patient also recently had an ileostomy created. It is unclear at this time the true 24-hr stool output from the stoma as the patient had not been measuring and the patient has been admitted to the hospital less than 24 hours, but dehydration is a common complication postoperatively for ileostomy patients. The patient did report liquid stools at home and frequent emptying of the appliance. The patient had pasty brown stool and only 25 ml in ostomy appliance during assessment, which is a good sign compared to liquid output. With previous documentation since patient was admitted to the hospital, 350 ml of stool output had been charted in about a 17-hour period. Unfortunately, the patient's urinary output has not been documented prior to assessment despite hospitalist instructions. Patient was receiving normal saline infusion via IV at 75/ml an hour during assessment. If I were able to see this patient again, I would re-evaluate the patient's pouching technique again, as it seems the patient is making stoma opening wider than his stoma side which is contributing to her peristomal MASD issues. The patient was also not using a liquid barrier skin protectant on peristomal skin prior to ileostomy pouch application on which he was educated on doing so. The patient could ideally be referred to an outpatient ostomy clinic for a follow up, however, the patient does not drive long distances, and the closest ostomy clinic is in downtown Orlando over 15 miles away from hospital site with limited hours. Luckily, home health will continue to follow the patient for ostomy education. The patient ideally would also benefit from a colorectal surgeon, but ostomy patients at this hospital are seen by general surgeons and referred outpatient to colorectal surgeons post operatively as there is no colorectal surgeon at this division currently.

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 learn see the concept of teaching patient care with a new ostomy if there is a consult available. Though no new ostomy teaching was available, I was able to assist in education for a patient with a 1-month post-operative end-ileostomy. The patient had to be re-educated on similar concepts that a fresh ostomy patient would be learning.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
To learn and see the concept of teaching patient care with a new ostomy if there is a consult available. I would also like to perform a stoma marking available. Pai-Yun did notify the general surgeon group to let her know if any stoma markings were needed for the next couple weeks on Tuesdays and Fridays for my clinical if possible.

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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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