Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ___Dana Cooper _____ Day/Date: _Day 1, 1/7/26_____

Number of Clinical Hours Today: _10___ Number of patients seen_**4**_

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

Preceptor: ___Stephanie Legare 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.

During this clinical day I saw 4 patients with my preceptor in the home care setting, we visited ostomy patients this day. The first patient we saw was a 46 y/o male with new diagnosis of colorectal cancer who was discharged home with a colostomy. His stoma was quite edematous at the time of this visit, he was sent home from the hospital with two-piece system, flat barrier wafer and bags. This patient required education on applying the pouching system, products to use, and how to care for his new ostomy. This patient verbalized feeling overwhelmed with his new situation, he will continue to need support in the home until he feels comfortable and confident with ostomy care. We also visited a 50 y/o female with a prolapsed ileostomy; the patient had the ostomy for some time and was able to manage it herself. However, she had been experiencing leakage which caused peristomal skin breakdown. Education was provided regarding the use of barrier film spray prior to the application of the skin wafer. We also discussed diet as the patient had stated she had an increase in effluent output. Next, we saw a 65 y/o man with a high output ileostomy, this patient had been struggling with his bag “blowing off” in the night. We reviewed with this patient proper diet to reduce gas and what foods may cause and increase in output. We also discussed with the patient their current routine for applying the pouching system. Lastly, we saw a 90 y/o women with a new ileostomy, that was having issues with leakage. This patient had a stoma that was flush to the skin and was sent home with a flat skin barrier and bag. Discussed the use of a convex skin barrier with a moldable ring and ostomy belt to help the stoma to protrude and decrease leakage. These supplies needed to be ordered for the patient as they were none in the home. A call was made to the patient’s primary care provider making recommendations for the use of a convex pouching system as new order will need to be entered into the chart. In addition to patient facing time, we also reviewed different products and their uses as well as what different brands have to offer (Coloplast, Hollister, NuHope). We spent time discussing stoma site marking, I was able to demonstrate this on my preceptor in the office.

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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:

Braden Risk Assessment Tool

Sensory Perception	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
Total	

90 y/o female who was admitted to home care services following creation of a new ileostomy with bowel resection secondary to adenocarcinoma of the colon. This patient had been admitted to the hospital for abdominal pain and reported no bowel movement for several days. CT scan revealed frank pneumoperitoneum with possible perforated cecal volvulus vs, perforated sigmoid diverticulitis. Patient with type 2 diabetes, currently on glipizide. Home care was referred for patient education for new ostomy. Since discharge home the patient has had difficulty with leakage of her pouching system. Patient reports she is having leakage after only a couple of hours after application on her pouching system. Patient is currently using a two-piece system with a flat skin barrier wafer. Patient was agreeable to an appliance change and assessment of the stoma and surrounding skin. Bag was noted to have liquid- mushy effluent present. Appliance was removed from RUQ. Moisture was noted to the bottom left of the skin barrier. Peristomal skin and stoma cleansed with warm water. Erythema noted to peristomal skin. Stoma is flush with the skin, it is round, moist and red. Powder is applied to the peri stomal area, then dabbed with skin prep wipe to form a crust. Cut to fit Hollister New Image Flat Flextend skin barrier with a moldable ring applied Hollister New Image drainage pouch attached to skin barrier. Demonstration and education were provided to the patient and her caregiver during appliance change. Education was provided to the patient and her caregiver regarding how to empty the pouch. Call was made to the patient's PCP to provide recommendations for changing from a flat appliance to convex and the use of an ostomy belt. Verbal order was received from PCP. Supply order was placed for Hollister New image convex flex wear skin barrier #13404, Hollister New image drainable ostomy pouch #18194.

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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)

1. Change appliance every 3-4 days
   a. Remove pouching system using push pull methods
   b. Cleanse skin and stoma with warm water, pat dry
   c. Measure stoma, cut skin barrier wafer to fit stoma
   d. Apply stoma powder to peristomal skin, then pat with skin prep wipe to crust
   e. Apply skin barrier wafer (Hollister New image convex flex wear skin barrier #13404), with moldable ring, and pouch (Hollister New image drainable ostomy pouch #18194)
   f. Secure in place with ostomy belt
2. Encourage patient to participate in pouching changes/ care
3. Notify PCP with any concerns, change in stoma color, lack of output, increased pain.
4. Encourage patient and caregiver to write down questions to discuss at next visit.
5. Encourage well balanced diet.
6. Monitor blood sugar as ordered

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

I feel that this patient should have been discharged home with more than one style of appliance. The flat skin barrier that she was sent home with did not work well with her flush stoma, creating leakage concerns and skin irritation. Getting home care involved and consultation from the WOC team was important for this patient. I would have called the PCP for the verbal order to switch the patient from a flat skin barrier wafer to the convex as we did at this visit. The convexity paired with a moldable ring and ostomy belt should help to protrude the stoma with a little bit of pressure. This will help the effluent to drain into the pouch instead of leaking under the wafer.

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 today was to assist with a pouching system change; this goal was met. In my previous experience I have not seen many ostomy patients. I was looking forward to practicing ostomy care and application of a pouching system

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What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) My learning goal for the next clinical day is to see a patient with a peristomal wound so that we can discuss treatment options.

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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