Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Nian Wan Day/Date: 4/01/08/2026

Number of Clinical Hours Today: 9 Number of patients seen **5**

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

Preceptor: Sarah Weisz

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 saw predominately ostomy patients. The following patients were:
Patient #1 - The first patient we had was a 73-year-old patient had a loop ileostomy and PEG. Pt was positive for RSV and *C. difficile* – thus were in droplet precautions. Changed the ostomy pouch without much difficult. Suction used to prevent leakage while stoma changed.
Patient #2 – the 66-year-old patient had PEG tube that the providers requested pouching. Patient declined the pouching and stoma powder applied and drainage tube applied. Pt reported pain and burning from leakage, tube stabilized with catheter stabilizer to minimize pulling of skin.
Patient #3 – 60-year-old patient with wound vac located on the sacral area due to necrotizing tissue as well as a sigmoid colostomy – placed a Marlen pouch.
Patient #4 – 54-year-old patient with history of diverticulitis at POD #1 ileostomy. Pt had history of perforated diverticulitis with colostomy. Pt was seen in the PACU with NG tube and PCA. Upon examination, the ostomy showed scattered slough.
Patient #5 – 66-year-old male with ileostomy that needed changing. Patient stoma friable due to skin impairment from varicosities.

Additional activities included reviewing with preceptor how choose the right ostomy appliance. Preceptor helped to reviewed how to approach ostomy patients to help ascertain appropriate ostomy to use.

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,

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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	3
Moisture	2
Activity	2
Mobility	2
Nutrition	2
Friction/Shear	2
Total	13

Chief Complaint: Small Bowel Obstruction

History of Present Illness: The patient is a 66-year-old male with a past history of hypertension, atrial fibrillation [on diltiazem], alcoholic cirrhosis with ascites, portal hypertension status post TIPS, coronary artery disease, deep vein thrombosis, tobacco use disorder, anemia, gastroesophageal reflux disease, and pT3N1a transverse colon cancer status post left segmental colectomy with diverting ileostomy. On 12/16/2025, presented to OHS complaining of right lower quadrant pain and multiple vomiting episodes. NG tube placed for decompression and transferred to Cleveland Clinic. On evaluation at the Cleveland Clinic, patient is lethargic, alert & oriented x 2. Denies any fever, chills, nausea, vomiting, abdominal pain. Patient reports starting chemotherapy two weeks prior [port in place]. The patient lives in skilled nursing facility.

Purpose of Visit: Schedule pouch change and assess pouch. The patient has a loop ostomy, irregularly shaped, approximately 2” by 1 ¾”. Located on right upper quadrant, protrudes slightly. Mucosal condition and color was red, moist, and edematous. Mucocutaneous junction intact. Peristomal skin had ulceration located 8 o’clock and 11 o’clock. Peristomal contour rounded. Supportive tissue is semisoft.
Character is output is mushy-yellow green, although prior report dark brown, watery.

Pouching system removed due to leaking. Hollihesive petals, paste, 2 ¾” HNI flange cut to fit, high volume output connected to gravity drainage with Mefix tape. Current wear time 3 days. The patient had some bleeding at 6 o’clock and 12 o’clock, aquacell applied. Full sheet Hollihesive cut into a washer, caulked with stoma paste around stoma, HNI 2 ¾” HNI high volume output to gravity drainage bag, Mefix tape picture framed around the flange.

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)

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Skin care:

1. Use ConvaTec Sensi Care No Sting adhesive remover wipes to gently release the worn pouch from the skin.
2. Apply ConvaTec Stomahesive powder to denuded/irritated skin as needed with each pouch change until healed.

Pouching System:

If there is need to change the pouch and patient bleeds, clean surrounding area with wet gauze and dry with dry gauze then apply aquacell. Use skin barrier powder and brush off excess powder and apply Sureprep No-Sting skin protective barrier around peristomal skin. Make a "frame" by cutting a 2 ¾" circle out of Hollihesive and use the cutout washer to frame the stoma, caulk around framed stoma with stoma paste. Use the provided HNI 2 ¾" flat flange over the stoma and cut to size [should be 2 ¾ inches]. Then attach the HNI 2 ¾" HVOP pouch by centering the pouch opening over the skin flange and snap together. Attach the end of pouch to the gravity drainage bag. Use Mefix tape, and frame around flange to prevent leaking. If patient's leaks despite change or unable to change the pouch, please contact ostomy service during the day. If unable to contact ostomy service more than 2 hours, page the patient's provider for assistance.

Pressure Injury Prevention

Braden Scale Score 13, which is moderate risk. Mitigate moisture through checking pouch for leaking. Empty gravity drainage bag as needed to prevent overflow. If patient's pouch leaking and unable to change pouch, contact wound ostomy service. If unable to contact wound ostomy service for more than 2 hours, contact patient's provider.

Check patient's skin at least every shift to make sure that patient's skin dry. If redness or irritation detected, wash skin gently with wet towel and dry with towel. Change pouch if leaking. Make sure that bony prominences are off the bed. Reposition patient every 2 hours or encourage patient to change positions in bed. Encourage hydration through offering fluids and observe the patient's intake. Consult nutrition if have any concerns with inadequate caloric intake. Observe bony prominences for any non-blanching redness. Apply heel/elbow protectors to intact skin if patient is unable to help transfer in bed.

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

Be prepared with supplies prior to entering room. Read the patient's chart and create a "game plan" prior to changing pouch. Look for "creases" and fill.

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?

Start to begin to do simple pouch changes with minimal supervision.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

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Will be outpatient service, watch a stoma marking again.
Begin to find patients to fulfill continence journal.

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	✓	
• 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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