Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ___Kelly Shemonis_____ Day/Date: ___1/9/26__

Number of Clinical Hours Today: __8__ Number of patients seen__**6**__

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

Preceptor: _CWOCN Janelle Holtz__

Clinical Focus: Wound __X__ 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.

Today I was inpatient WOC with preceptor Janelle Holtz until 2pm, then with Bobbi Jo Killing. We saw a total of 6 patients. The 1st patient was a 50-year-old male with a history of colon cancer, post-op day two for a diverting loop ileostomy. The patient was seen to assess the fit of the pouching system due to leakage. This visit included an educational lesson 1 and 2. The patient was unable to fully participate in lesson 1 yesterday; therefore, that information was reviewed, along with participation in changing the pouching system. He will receive one more lesson 2 tomorrow with his sister present before he is discharged home. The 2nd patient was a 73-year-old male with an ileal conduit, colostomy, and JP drain. This was interesting because the JP drain had to be pouched also due to leakage around the drain site. The third patient was a 65-year-old male with a left groin wound that required placement of a wound VAC s/p debridement of the site. It was in a challenging location due to skin folds. My preceptor demonstrated an alternative technique for framing the site and cutting the foam in a spiral pattern to facilitate application. I will discuss this patient in more detail in the chart note. The 4th patient was scheduled for a wound VAC dressing change for an RLE wound. The 5th patient was a 17-year-old female s/p diverting loop ileostomy. I actually saw this patient in clinic for stoma site marking on Tuesday. Today, the education was directed towards her mom because the patient was experiencing pain and muscle spasms and was drowsy from her medications. The last patient was a 73-year-old female for a scheduled fistula management system change. The fistula was located in the mid-abdomen, and several creases and folds had to be built up before applying the pouch. We used strip paste in the creases and Holliadhesive to cover the area, thereby providing a flat surface that the system could adhere to. I have limited experience with fistulas, so this was a valuable learning opportunity.

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

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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	3
Activity	2
Mobility	3
Nutrition	3
Friction/Shear	2
Total	16

NPWT dressing application
Patient is a 65-year-old male with a history of CHF, DM, hyperlipidemia, and heart transplant on 11/25/25. After removal of ECMO, pt developed an infected left groin hematoma. 12/18/25: taken to the OR for debridement; pt completed antibiotics. Bedside debridement on 1/6/25 and now scheduled for VAC placement. Medications reviewed. Patient awake and alert in bed with 2 family members at bedside. Reason for visit explained, pt agreeable to visit with family present. Denies pain. Left groin wound measures 9.5 cm x 3.5 cm x 4.4 cm, with no undermining or tunneling. Wound bed is red and moist. Periwound skin intact. Moderate serous exudate. No odor. Wound bed irrigated with normal saline, periwound cleansed, and 3M Cavilon no-sting skin prep applied. Transparent film used to picture frame site. Small piece of barrier paste placed in crease at 9 o'clock and covered by Hollihesive wedge. Black foam spiral cut and fabricated to fit wound bed. 2 pieces of foam used, one to wound bed and one for trackpad. Negative pressure applied to -75MMHG, low continuous pressure as ordered, adequate suction achieved, no leaks detected.
Procedure well tolerated, no complaints of pain. Patient/family education provided on condition of wound and purpose of NPWT. Patient and family have no questions at this time. Next visit scheduled for 1/13/26.

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)

-NPWT: -75 mmHg low continuous suction; change Tues/Friday.
-irrigate wound with normal saline. Cleanse periwound then apply 3M Cavilon no-sting skin prep and allow to dry. Picture frame site with transparent film. Place a small piece of Brava barrier strip to crease at 9 o'clock, and cover with Hollihesive wedge cut to size. Apply black foam, spiral cut to fit the wound bed. Use a piece of black foam as a track pad on the anterior upper thigh. Cover with drape. Attach to -75 mmHg low continuous suction.
-Change the VAC canister as needed and record the output.
-If NPWT unit is alarming and bedside nurse is unable to resolve issue, call WOC nurse.
-If without suction for more than 2 hours, remove black foam and apply wet to dry dressing, and notify WOC nurse.
-Place a consult or call for question/concerns with the wound or NPWT.
-Monitor blood sugars and treat as indicated.
-Encourage PO intake and consumption of Glucerna shakes as recommended by RD.

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

The RD had already seen the patient and recommended the Glucerna shakes and likely provided education. However, I would have inquired whether the patient was drinking the shakes and discussed/reinforced the importance of optimal nutrition/protein for healing with the family and patient.

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 was to observe lesson 2 ostomy education. This was partially achieved with the first patient we saw.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) Monday, I will be in A30 outpatient WOC. My goal is to participate in stoma site marking.

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:		

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• 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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