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, RN, BSN, PCCN Day/Date: Wednesday/January 28, 2026

Number of Clinical Hours Today: 8 Number of patients seen **6**

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

Preceptor: GIVEN, ASHLEY & HENSLEY, JENNIFER

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.

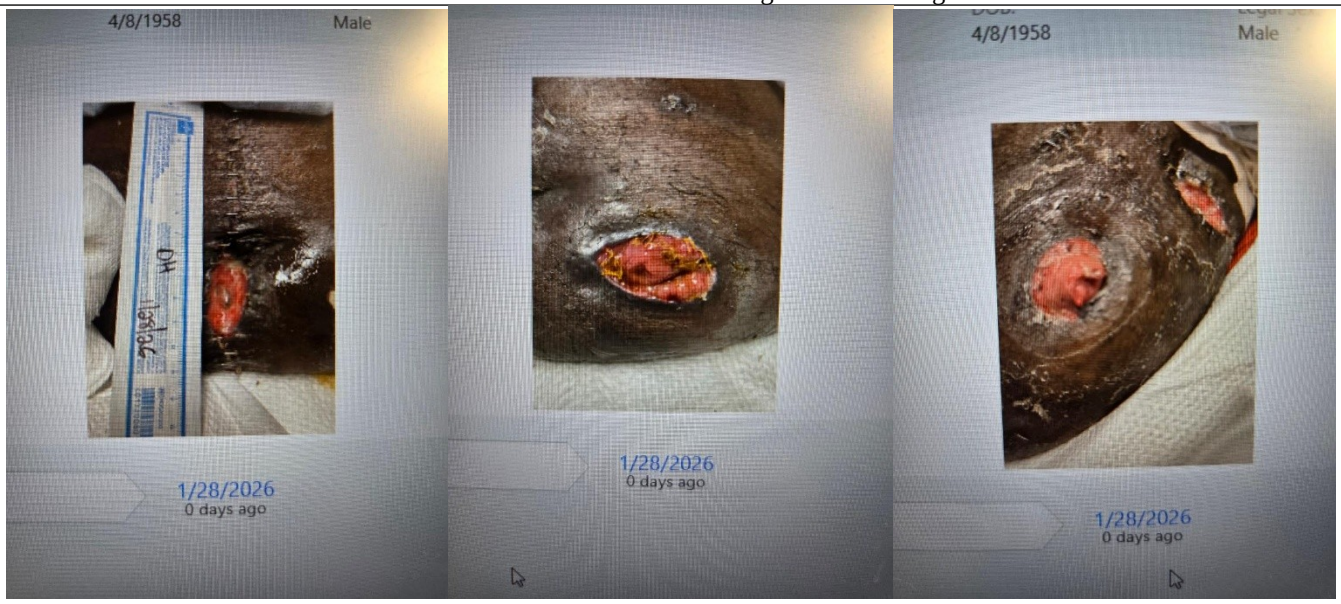
Reflection: Describe your patient encounters, types of patients seen, and any additional activities.

During this clinical day, I participated in inpatient WOC consultations with a primary focus on ostomy management and complex wound care. I assisted with care for six hospitalized patients with a variety of wound, ostomy, and continence skin integrity concerns.

The primary patient encounter involved a 67-year-old male with both an ileostomy and urostomy, complicated by peristomal skin risk, a midline surgical wound, and bilateral buttock friction and shear injuries related to immobility, moisture, and decreased tissue tolerance. This patient required comprehensive ostomy assessment, product selection, and coordination of care to prevent leakage, protect peristomal skin, and reduce further skin breakdown.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

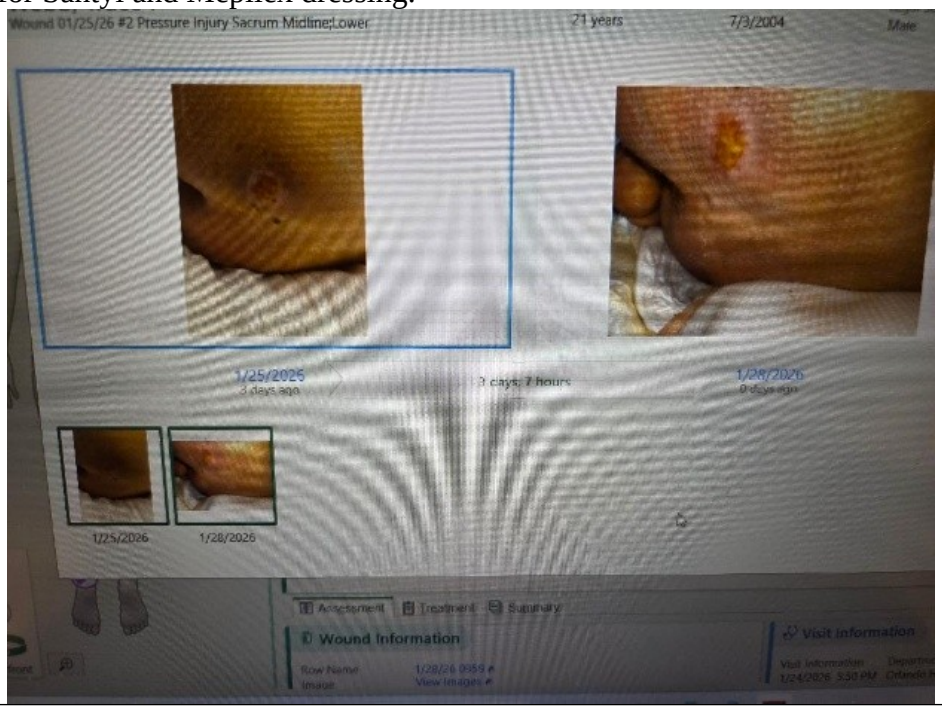
Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.



(Pictures from left to right: Abdominal Wound, Ileostomy Stoma, Urostomy Stoma)

Additional patients included:

1. 21-year-old male with a prolonged hospitalization following a motor vehicle accident complicated by substance use disorder, refractory shock, respiratory failure requiring tracheostomy, acute kidney injury requiring dialysis, multiple infections, amputation of necrotic toes, malnutrition, and pressure injuries. His care highlighted the importance of multidisciplinary coordination and ongoing wound and skin integrity monitoring in younger patients with severe critical illness. New wound care orders were initiated for Santyl and Mepilex dressing.

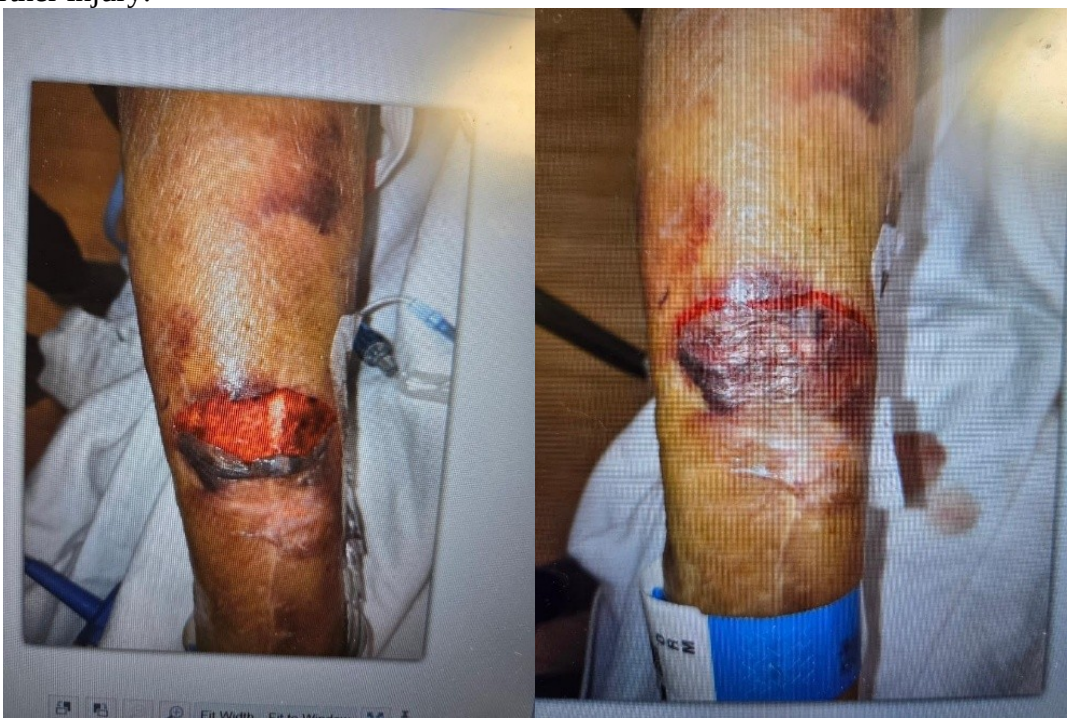


(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

2. A 75-year-old female was seen in follow-up for ostomy management. Her appliance had been changed the day prior from a one-piece cut-to-fit system to a two-piece high-output ostomy system due to increased effluent. The follow-up visit focused on reassessing appliance fit, wear time, and peristomal skin condition to ensure continued containment and skin protection. Translator services were also used to ensure the patient understood her plan of care and also to ensure her family had begun reading through materials provided for ostomy care.

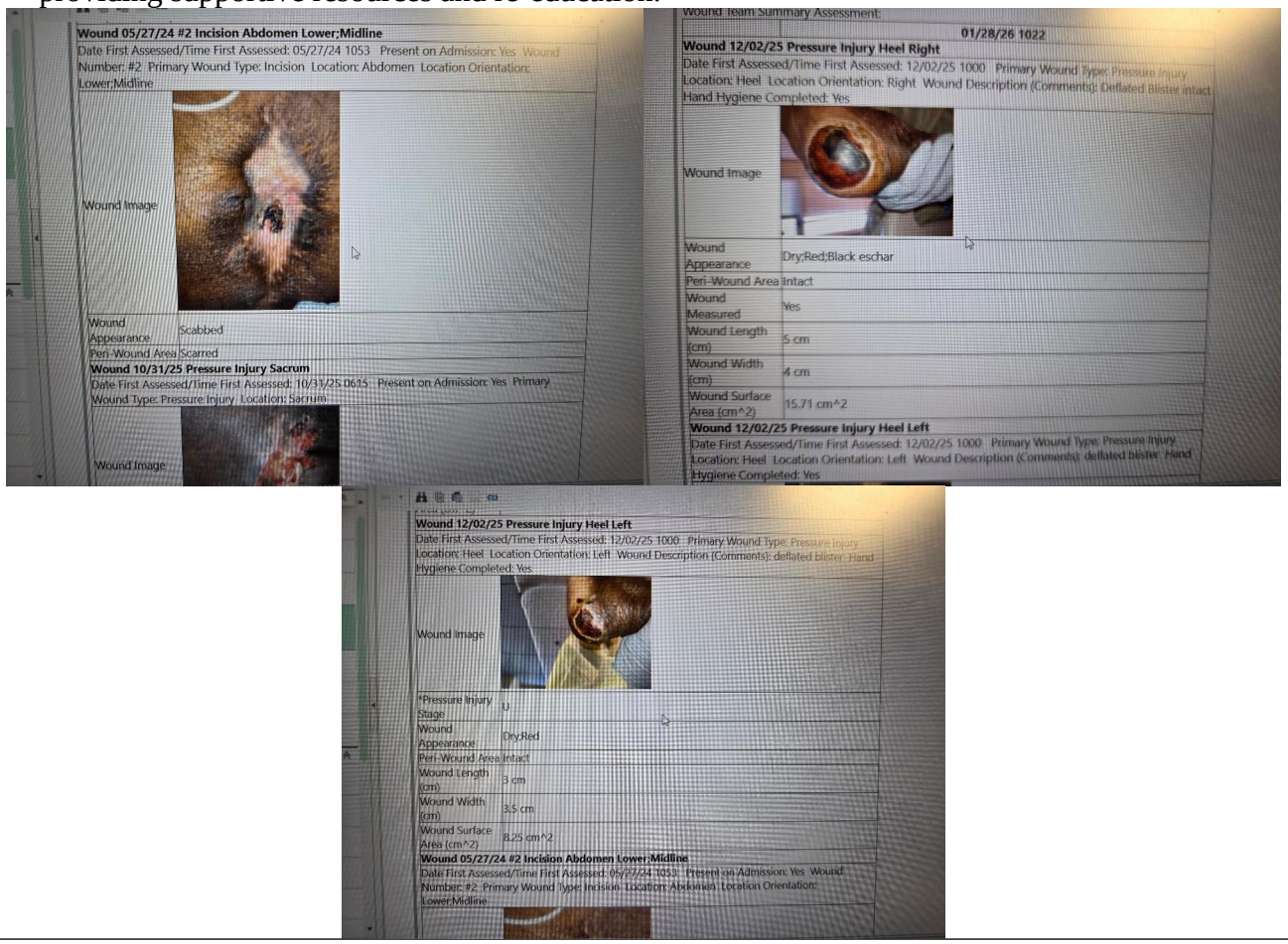
3. A 68-year-old male with significant cardiac history, including a-fib on Eliquis, NICM, HTN, GERD, gout, and recent transcatheter mitral valve replacement, was evaluated for skin integrity concerns related to anticoagulation and fragility. The patient presented with a traumatic skin tear to the right forearm with surrounding ecchymosis. The wound was gently re-approximated, cleansed with normal saline, patted dry, and PolyMem was applied, secured with Kerlix and Medipore tape. Due to extensive ecchymosis and fragile skin, the patient was educated on the use of protective garments (we applied Geri-sleeves at the time of consultation) to reduce the risk of additional skin injury, as the patient is an avid woodworker and spends a lot of his time in his workshops! Also, a prophylactic OptiView foam dressing was applied to the sacrum despite intact skin, there was a bony prominence noted at the top of the sacrum, given his risk for pressure injury. Bilateral heels were assessed and noted to be dry with cracked skin and blanchable erythema. The patient reported to us that he uses cocoa butter at home to maintain skin hydration and prevent breakdown. Heel off-loading and pressure redistribution were reinforced. This encounter emphasized the importance of preventative skin care, patient education, and product selection in anticoagulated patients with fragile skin to reduce further injury.



4. A 60-year-old female was evaluated for right knee hematoma which burst the night prior. The patient

presented to ORMC after sustaining a fall on the way to one of her appointments. Her husband was at bedside and confirmed that she did not lose her balance nor hit her head (which they were very grateful for, as this is her second fall within the past 6 months)-she tripped over something in the parking lot. CT scan had confirmed hematoma, and physical therapy had been working with her. The knee was cleansed with normal saline, patted dry, PolyMem was secured with Kerlix and Medipore tape. The patient was on track to being discharged that day and required wound care orders.

5. A 62-year-old male with a complex medical history, including DM, a-fib on anticoagulation, CKD post renal transplant, and prolonged critical illness, was evaluated from multiple pressure injuries and surgical wound healing. The patient was initially seen in the ICU earlier in his hospitalization and had since clinically improved and had been downgraded to a PCU level of care. He had bilateral heel pressure injuries, a sacral pressure injury, and healing lower midline abdominal incision. Wound assessments were completed, and pressure redistribution, heel off-loading, and skin protection were reinforced. Education was also provided to the patient and his wife, who is currently in nursing school and expressed interest in wound care. Since moving to a different floor, it was noted that current wound care orders were not being followed, which was addressed with leadership and nursing staff-providing supportive resources and re-education.



(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

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:
Reason for Consult:
WOC nursing consult for management of dual ostomies (ileostomy and urostomy), assessment of peristomal skin integrity, and evaluation of multiple wounds including a midline abdominal wound and bilateral buttock friction and shear injuries.

History of Present Illness:
The patient is a 67-year-old male admitted with a history requiring both an ileostomy and a urostomy. He presents with established ostomies requiring routine appliance changes every 3–4 days and as needed for leakage. Nursing staff requested WOC consultation for assessment of ostomy function, pouching system effectiveness, and peristomal skin protection. The patient also has a midline abdominal surgical wound and bilateral buttock friction and shear injuries, placing him at increased risk for further skin breakdown. The patient is currently managed on a low air loss bed with turn assist due to impaired mobility and increased pressure injury risk.

Physical Assessment – Ostomy Section
Ostomy Assessment:

- Ileostomy: Stoma present measured using measuring guide; output managed with drainable pouch. Peristomal skin at risk for moisture-associated skin damage due to liquid effluent. No active leakage noted at time of assessment.
- Urostomy: Stoma present with continuous urine output; pouching system intact. Peristomal skin assessed and found at risk for moisture exposure related to urine output. No leakage noted at time of assessment.
- Both ostomies require consistent appliance management, appropriate barrier use, and routine reassessment to prevent skin complications.
- Education was provided to nursing staff regarding differences in pouching needs for ileostomy versus urostomy, importance of emptying frequency, and maintaining a secure seal for both systems.

Products Utilized / Recommended:

- Convatec Moldable Flat 57 mm wafer (#79318)
- Convatec 57 mm drainable pouch for ileostomy (#79322)
- Convatec urostomy pouch with bedside drainage option (#56027)
- Eakin cohesive ring (#20704)

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

- Stomahesive powder (#408)
- Cavilon No Sting Barrier Film (spray or wipes)
- Esenta adhesive remover spray or wipes
- Brava strips
- Aquacel Ag rope
- Mepilex foam dressing
- Antimicrobial wound cleanser (Anasept)

Braden Risk Assessment Tool
Sensory Perception: 3
Moisture: 3
Activity: 3
Mobility: 3
Nutrition: 3
Friction/Shear: 2
Total Score: 17 (At 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)

- Manage ileostomy and urostomy appliances separately, ensuring appropriate pouch type is used for each stoma.
- For urostomy, ensure continuous drainage is maintained; connect pouch to bedside drainage bag as needed to prevent backflow and reduce leakage risk.
- Empty ileostomy pouch when one-third full; empty urostomy pouch as needed based on urine output.
- Monitor peristomal skin around both stomas every shift for signs of moisture-associated skin damage.
- Change ileostomy appliance every 3–4 days and immediately for any signs of leakage.
- Empty ostomy pouch when one-third full to maintain adhesive integrity.
- Remove appliance using Esenta adhesive remover spray or wipes.
- Cleanse peristomal skin gently with warm water and gauze; avoid bath wipes.
- Pat skin dry thoroughly.
- Measure stoma with measuring guide each change.
- Apply Cavilon No Sting Barrier Film to peristomal skin; allow to dry.
- If peristomal skin is moist or irritated, apply light dusting of Stomahesive powder followed by barrier film (“crusting technique”).
- Mold Eakin cohesive ring around stoma opening to fill creases and enhance seal.
- Apply Convatec moldable flat wafer, ensuring backing is removed prior to placement.
- Attach Convatec drainable pouch securely to wafer.
- Apply gentle warmth or have patient place hand over appliance for 2–3 minutes to promote adhesion.
- Continue abdominal wound care per current orders: cleanse with antimicrobial cleanser, gently pack with Aquacel Ag rope, cover with Mepilex foam; change every 48 hours.
- Cleanse buttock wounds with gentle cleanser; apply hydrophilic wound dressing as ordered.
- Maintain low air loss bed with turn assist; reposition patient at least every 2 hours.

- Utilize lift sheets for all repositioning to minimize shear.
- Keep skin clean and dry; manage moisture promptly.
- Reassess wounds and ostomy site every shift and notify WOC nurse of any deterioration.

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

This encounter reinforced the importance of addressing ostomy management within the context of the patient's overall skin integrity and mobility status. The plan of care was appropriate and comprehensive. In future encounters, I would focus on earlier involvement of bedside nursing education to proactively prevent peristomal skin breakdown and reinforce consistent turning and moisture management strategies to reduce shear-related injuries.

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 strengthen my ability to assess complex ostomy needs while integrating wound prevention strategies and developing clear, directive nursing orders.
Was it met? Why or why not?
Yes. I was able to perform a comprehensive ostomy and wound assessment, identify contributing risk factors, and formulate a holistic plan of care aligned with WOC nursing standards.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
To continue refining my clinical judgment related to ostomy product selection and to further develop efficiency in translating assessments into concise, actionable nursing orders.

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	✓	

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.