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 Day/Date: Tuesday/February 24, 2026

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

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

Preceptor: Given, Ashley

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.

1. **Primary Patient – Suprapubic Catheter Exchange (Chronic Urinary Diversion)**

The 82-year-old female with a history of recurrent UTIs underwent routine suprapubic catheter exchange. Her stoma site was clean, pink, and intact without erythema, maceration, or hypergranulation. Urine was clear, yellow, and odorless. A 16 Fr catheter was exchanged using sterile technique, balloon inflated with 10 mL sterile water, and secured with a new StatLock.

*This case reinforced several WOC continence principles:

- ✓ Long-term indwelling catheters create chronic biofilm risk.
- ✓ Securement devices are essential to prevent micro-movement and tract trauma.
- ✓ Stoma assessment must include inspection for hypergranulation, fungal involvement, moisture-associated damage, and early cellulitis.
- ✓ Closed system maintenance and minimizing catheter manipulation are foundational to CAUTI prevention.

Although this was a routine exchange, the patient's history of recurrent UTIs highlights the importance of consistent sterile technique and strict adherence to infection prevention standards.

2. **Secondary Patient – Acute Skin Failure (Braden 12, ESRD, Cardiac Arrest)**

The 53-year-old female with ESRD, recent cardiac arrest, and multisystem compromise presented with a Braden score of 12 indicating high risk for pressure injury. Assessment findings and clinical course were consistent with acute skin failure related to impaired perfusion and systemic instability.

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Multiple areas demonstrated tissue compromise involving the sacrum, thighs, lower extremities, and elbow. Given her hemodynamic instability, hypoperfusion, and renal dysfunction, the tissue changes were consistent with skin failure rather than isolated pressure injury.

*Interventions initiated:

- ✓ PolyMem applied to all affected areas for moisture balance, inflammation modulation, and atraumatic coverage.
- ✓ Aggressive offloading strategies reinforced.
- ✓ Moisture management implemented.
- ✓ Ongoing support surface utilization emphasized.

This case reinforced that in critically ill patients, skin acts as an "end organ" vulnerable to hypoxic injury. Differentiating pressure injury from skin failure is essential to appropriate documentation, staging, and management planning.

3. Third Patient – Tracheostomy Site Complication (Medical Device–Related Injury)

The 66-year-old female admitted with symptomatic bradycardia and tracheostomy complication demonstrated localized breakdown at the tracheostomy site.

*Assessment revealed tissue irritation and localized breakdown consistent with:

- ✓ Moisture-associated skin damage (from respiratory secretions)
- ✓ Possible medical device–related pressure injury (MDRPI) from trach flange/ties

*Interventions:

- ✓ Aquacel Ag applied to provide antimicrobial coverage and manage exudate.
- ✓ Aquacel ointment applied to protect surrounding skin and promote moisture balance.

*This case emphasized:

- ✓ The vulnerability of tracheostomy sites to both mechanical pressure and chronic moisture exposure.
- ✓ The importance of differentiating fungal rash, pressure injury, and chemical irritation from secretions.
- ✓ The need for routine flange repositioning and moisture control to prevent progression

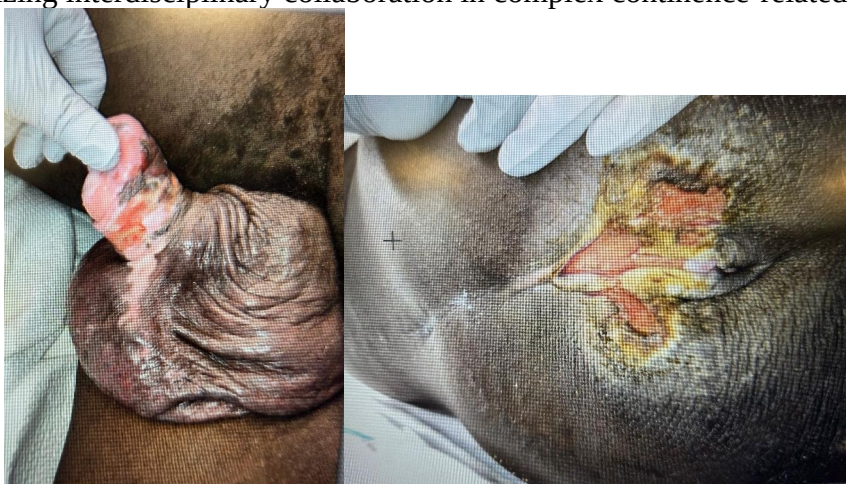
These cases reinforced that continence practice extends beyond urinary elimination. It includes:

- Device stabilization
- Moisture management
- Perfusion assessment
- Pressure redistribution
- Infection prevention
- Multisystem impact recognition

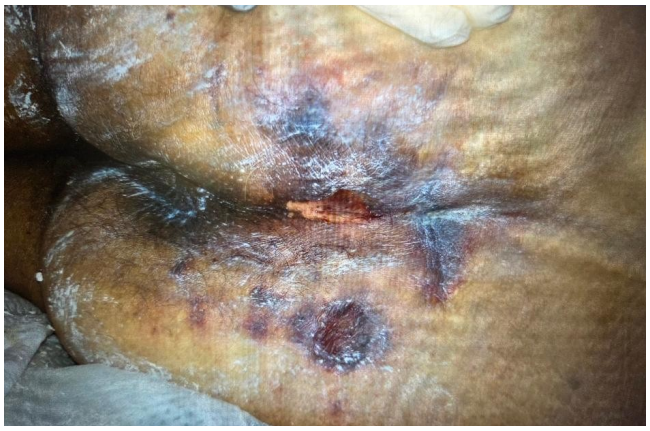
Additional patient encounters further reinforced the complexity of continence and WOC nursing across diverse etiologies of skin and urinary diversion complications.

A 42-year-old male with spina bifida and osteomyelitis presented with sacral and genital tissue breakdown complicated by moisture exposure and impaired mobility. Triad hydrophilic wound dressing was initiated to manage excessive moisture and protect denuded tissue. Urology consultation was obtained due to genital

involvement, emphasizing interdisciplinary collaboration in complex continence-related wounds.

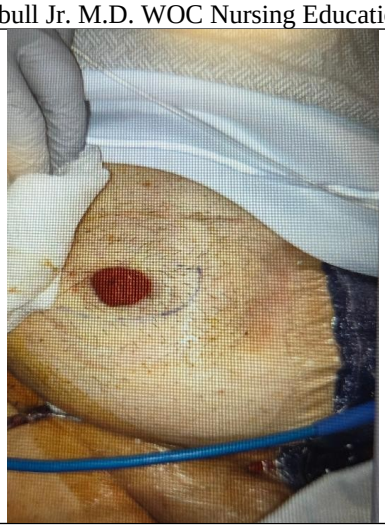


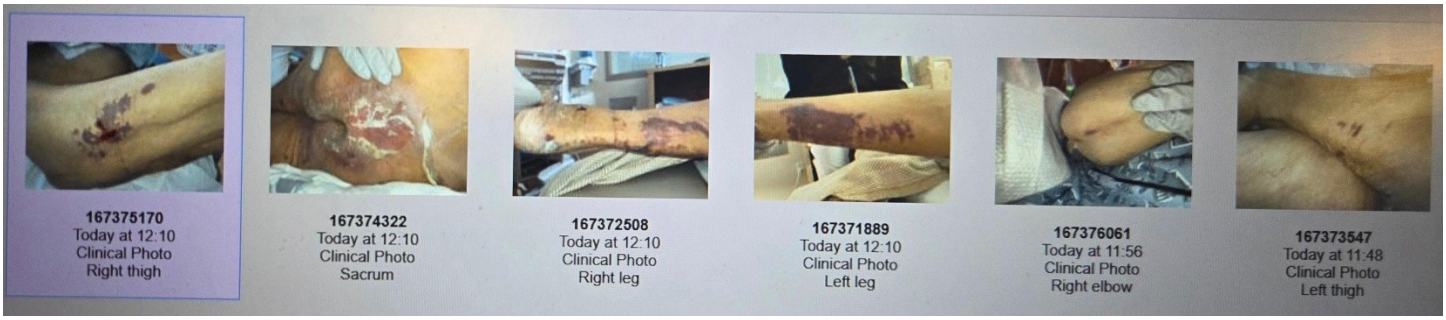
Another patient demonstrated areas consistent with skin failure, in which Triad was utilized to provide moisture barrier protection and support autolytic healing in the setting of systemic compromise and impaired perfusion.



Additionally, a postoperative patient returned to the unit with an inappropriate pouching system applied over a newly created urostomy. A complete pouch change was performed using an appropriate urostomy appliance to ensure urine diversion, prevent peristomal skin injury, and maintain effective seal integrity.

These additional encounters highlighted that continence management extends beyond catheter care and includes recognition of moisture-associated skin damage, medical device–related injury, postoperative ostomy management, and systemic skin failure. Early protective interventions and appropriate product selection remain essential to preventing wound progression and preserving skin integrity.





(Above) Patient #2-Braden Scale Assessment, multiple areas of skin failure, 2 areas with new skin tears.
(Below)Patient #3- Old Trach site assessment and scabbed area on left lateral thigh (nurse alerted CWOCN while we were in the room of this site).

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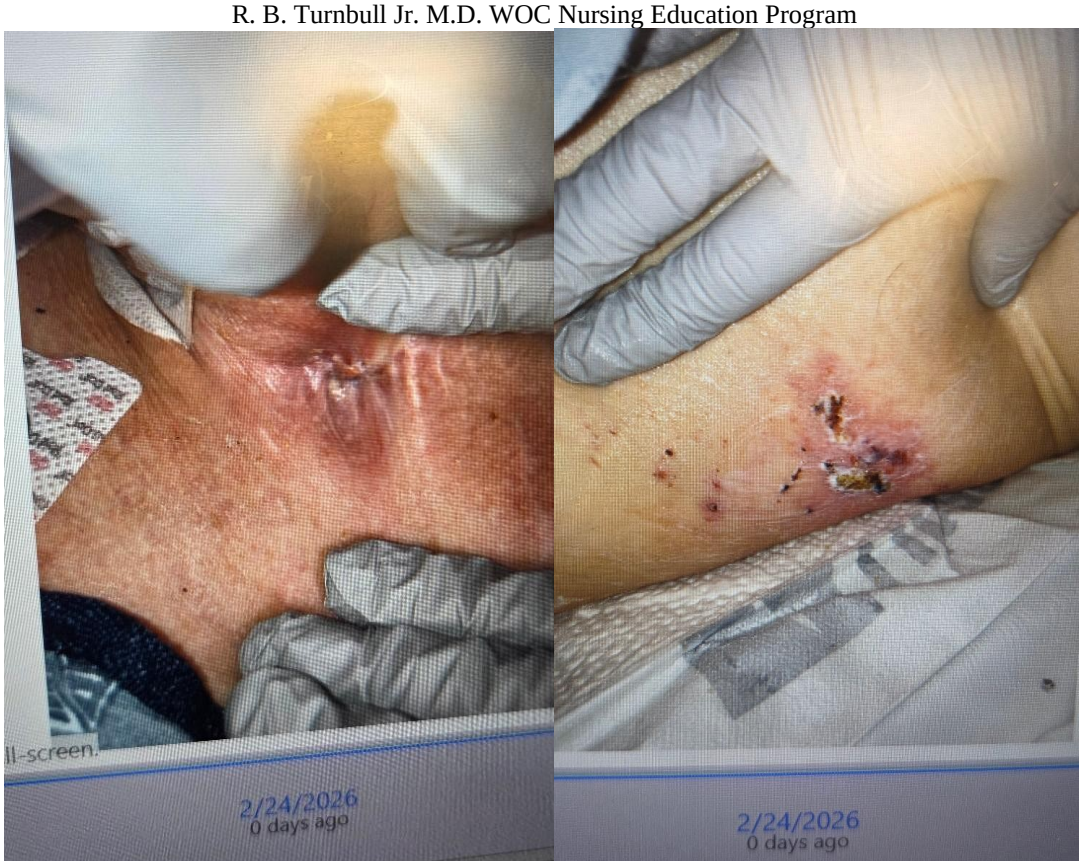

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history 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.

Continence-Focused Chart Note:

Reason for Consult:

- Suprapubic catheter exchange (routine) in patient with history of recurrent UTIs.
- Assessment
- 82-year-old female resting in bed, alert and oriented, in no acute distress. Patient provided verbal consent for suprapubic catheter exchange.
- Existing 16 Fr suprapubic catheter intact
- Urine yellow, clear, no foul odor
- No sediment noted

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- Stoma site clean, pink, and intact
- No erythema, drainage, maceration, induration, or hypergranulation tissue observed
- No evidence of peristomal dermatitis
- Securement device (StatLock) present and replaced during procedure
- Patient has history of recurrent UTIs; suprapubic catheter placed November 2025.

Procedure:

- Balloon deflated with 10 mL sterile water
- Site cleansed with castile wipes followed by betadine x3 using sterile technique
- 16 Fr suprapubic catheter inserted to level of bladder without resistance
- Immediate return of clear yellow urine
- Balloon inflated with 10 mL sterile water
- Catheter secured to right upper thigh using new StatLock securement device
- Sterile technique maintained throughout procedure
- Patient tolerated procedure well
- Clinical Rationale (WOC Core Concepts)
- Suprapubic catheters reduce urethral trauma but remain high risk for:
- Biofilm formation
- Bacterial colonization
- Recurrent ascending UTIs
- Encrustation and blockage
- Device-related skin injury

- Routine catheter exchange under sterile technique is critical to interrupt biofilm accumulation and reduce infection burden. Securement device replacement is essential to prevent:
    - Micro-movement at cystostomy site
    - Tract enlargement
    - Leakage
    - Skin trauma
    - Mechanical irritation

- Stoma assessment is equally important to monitor for:
    - Hypergranulation
    - Fungal involvement
    - Peristomal moisture-associated skin damage
    - Early cellulitis
    - Clear, odorless urine at time of exchange suggests no active acute infection.

Braden Risk Assessment:

Sensory Perception	4
Moisture	3
Activity	3

Mobility	3
Nutrition	3
Friction/Shear	2
Total	18

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)

- Maintain closed urinary drainage system at all times.
- Ensure catheter tubing remains secured with StatLock to minimize traction and microtrauma.
- Maintain drainage bag below level of bladder; avoid dependent loops.
- Perform daily stoma site assessment for erythema, drainage, induration, hypergranulation.
- Cleanse stoma site daily with mild cleanser and pat dry.
- Avoid occlusive dressings unless drainage present.
- Encourage adequate hydration as medically appropriate to reduce urinary stasis.
- Monitor for signs/symptoms of CAUTI:

✓ Fever
✓ Cloudy urine
✓ Foul odor
✓ Suprapubic tenderness
✓ Acute mental status changes

✓ Replace catheter per established schedule to reduce encrustation and biofilm burden.
✓ Avoid unnecessary catheter manipulation.

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

Critical Thinking

Although the exchange was routine and uncomplicated, the patient's history of recurrent UTIs requires ongoing vigilance. Long-term indwelling urinary devices create an environment conducive to biofilm formation and chronic colonization. Strict adherence to sterile technique during exchanges and maintaining a closed system are essential components of CAUTI prevention.

Additionally, securement strategy plays a significant role in maintaining tract integrity and preventing mechanical trauma that may predispose to leakage or infection. Replacing the Stat-Lock was an important intervention to ensure optimal stabilization.

Given the patient's age and history of seizures triggered by UTIs, infection prevention is particularly critical, as systemic infection may contribute to neurological destabilization.

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

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Goals

What was your goal for the day?

To strengthen clinical competence in suprapubic catheter exchange technique while integrating CAUTI prevention principles and long-term continence device management. As a developing WOC clinician, I am recognizing the importance of not labeling all breakdown as "pressure." Accurate identification of etiology guides appropriate treatment and documentation integrity.

Professional Growth Reflection

*Today strengthened my ability to:

- ✓ Perform sterile suprapubic catheter exchanges confidently.
- ✓ Recognize systemic skin failure versus pressure injury.
- ✓ Identify and manage medical device–related skin injury.
- ✓ Apply appropriate advanced dressings based on wound etiology.
- ✓ Integrate Braden scoring into clinical decision-making.

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

My goal moving forward is to continue refining my ability to distinguish pathophysiology-driven tissue compromise and apply targeted interventions supported by WOC standards of care.

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	✓	

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Reviewed by: _____ Date: _____

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