Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Stacy Ann Bruce Day/Date: 1/10/2025

Number of Clinical Hours Today: 8

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

Preceptor: Aaron Fischer

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.

During today's rotation in inpatient wound care, we saw a variety of patients, primarily focused on those needing ostomy bag changes and those experiencing pouch leakage. However, in alignment with my goal, my preceptor guided us to assess and manage patients with wound vacs**.** We saw about four patients who required wound vacuum-assisted closures (wound vacs). I was able to independently set up an initial wound vac and perform three wound vac changes with my preceptor, which provided valuable hands-on experience in managing chronic and complex wounds. This allowed me to further refine my skills in wound care management and vacuum therapy, while also learning to balance the needs of patients with ostomy concerns and more intricate wound healing challenges.

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. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc Then, describe the visit. Be sure to include any physical assessment, interactions, and specific products were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

Patient is a 67-year-old female with a history of anoxic brain injury s/p PEA arrest 3 months ago, non-verbal, trach and PEG dependent, afib on Eliquis who presented with suspicious for necrotizing fasciitis. Patient presented to ED for G-tube malfunction and removal patient family reported purulent fluid coming from peg site. Patient started on ciprofloxacin and vancomycin. CT scan showed ventral abdominal wall fluid filled percutaneous gastrotomy tract, inflammation and localized subcutaneous gas. Patient Lactate 2.5, WBC 14.64 febrile. Wound debridement performs and pt transfer to SICU. Patient wound measures 45 cm x 20 cm with a depth of 6 cm. The wound bed is ow granulating with healthy, beefy red tissue and no further necrotic areas. There is still some slough tissue present, edges of the wound are clean, slightly rolled, wound has moderate

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serous exudate**,** mild erythema at the edges but no increased warmth or purulent drainage. Patient premedicated with IV morphine by RN. Wound was cleansed using normal saline to remove any debris or loose slough. A foam dressing was selected to fit the wound size. The dressing was cut to size and placed in direct contact with the wound bed. A transparent adhesive drape was applied to seal the edges, ensuring complete contact and no air leaks. **v**acuum-assisted closure (Wound VAC) device was applied. The system was connected to a negative pressure wound therapy (NPWT) unit, with a setting of -125 mmHg to provide continuous suction. The wound was successfully sealed with no leaks around the edges. The patient tolerated the procedure well. No adverse reactions or signs of discomfort during the placement of the wound VAC

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 used)

- Change wound vac dressing next 48 hours.
- Monitor patient for infection, leakage, or discomfort.
- Continue with pain management as needed, with regular assessment for changes in the wound status.
- Continue Wound VAC therapy as part of the wound management plan for further drainage and wound healing.
- Reassess wound status and patient comfort regularly.

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

The decision to initiate Wound VAC therapy was a crucial step in promoting healing, minimizing wound infection, and managing excessive exudate. One thing I observed the wound care nurse did was apply clear adhesive tape to the edge of the wound before he placed the foam his rational was if there is any drainage from the wound that touch the outer portion of the patient skin that it would provide protection from skin break down. Asking for the patient to be given patient medication before the wound vac was place was very appropriate since the patient was nonverbal and was unable to communicate their pain level. I agreed with the care provided.

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 the day was to gain hands-on experience in wound care management, ostomy pouch changes and specifically focusing on Wound VAC therapy. I aimed to develop my skills in setting up and managing wound vacs, as well as understanding the process of wound assessment and patient education related to ongoing care.

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Additionally, I wanted to observe and assist in wound debridement procedures and learn how to monitor wound healing effectively. Since wound vacs were a key part of today's cases, I was particularly focused on learning the technical aspects of dressing changes, ensuring proper placement, and identifying signs of infection or complications. I was able to set up wound vac, change wound vac dressing and did several ostomy pouch changes.

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

My next rotation with the inpatient wound care team. My goal will be wound assessment and dressing change

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	✓	
• 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	✓	
• 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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