Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Patrick Willis_____ Day/Date: Wednesday, 4/30/25

Number of Clinical Hours Today: __8__

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

Preceptor: __Erica Yates_____

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.

We started the day with 6 patient consults on our list, but I only ended up seeing 4. One patient requested female caregivers only, so I was unable to participate with her care. Another patient with a sacral wound already had his dressing changed by the nurse that morning and had just been transferred to his wheelchair for a little time out of bed. My preceptor decided to follow-up on his wound at a more convenient time another day.

One of the more interesting encounters of my time so far involved a woman with bilateral BKAs who has a habit of presenting to the ED for infections and then leaving AMA. She is homeless with clear needs for some psychiatric support. She was verbally abusive to every provider who entered her room, but each staff member maintained a calm and professional demeanor. My preceptor has treated her buttocks wounds on the last few visits and expressed needing a break from seeing her should this patient present again in the near future.

Types of patients: pressure injury, dehiscence, fungating tumor, MASD/fungal

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 beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

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Chart note:

Consult requested by MD for opinion on abdominal wound. 45 y/o female admitted for diffuse large B cell lymphoma seen on oncology unit today prior to scheduled CT scan.

PMH: multiple abdominal surgeries, cholecystectomy, appendectomy, duodenal switch surgery, hernia repair x3 with mesh placement, recurrent partial small bowel obstructions, obesity. Medications and labs reviewed. HB 8.2, HCT 26.6, creat 0.51, CA 8.1

HPI: diffuse large B cell lymphoma, presenting to the hospital with recurrent LLE swelling and involuntary jerking motions of L foot. Patient had ex-lap on 2/20. Her surgical incision healed but shortly after, an area above the belly button reportedly "popped out". There is a 2.3 x 1.8 cm wound protruding 1.5 cm, soft without induration, but not compressible/reducible. Appears hernia-like. The wound is red and yellow/white with an area of brown eschar on the top. Small to moderate yellow drainage without odor. Patient reports tenderness and irritation when rubbed by waistband or clothing. The wound was wrapped with a thin strip of Aquacel to absorb drainage and covered with a foam border dressing to protect from friction. Primary team contacted and recommended general surgery consult for this area.

Patient also has a healing blister to the top of left foot which is covered with thin dry brown nonviable epidermis. Patient reports significant swelling of left leg that caused this blister. Encouraged lotions to keep site from drying out, but no further dressings needed at this time. Primary team contacted and recommended Vascular consult for left leg to evaluate ABIs and appropriateness of compression therapy to relieve edema.

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	2
Total	17

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)

Abdomen – remove old dressing, cleanse wound with normal saline or wound cleanser and pat dry. Wrap Aquacel (packing strip or cut into a strip) and cover with an Allevyn foam dressing. Change daily and as needed.
Left foot – apply Sween Cream BID.

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Re-consult wound care service if further needs arise.

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

This was an interesting wound that stumped us upon assessment. With the patient's history of hernias, this ended up being the best explanation at the time, but ultimately felt it was best to loop in the surgery team for an additional opinion. We were able to relieve the patient's primary complaints of drainage leaking onto her clothes and pain from rubbing, which she was happy about.

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 experience more rare wound types. While it is still unclear what this woman had going on with her abdominal incision, it was a good experience seeing something unexpected and without obvious explanation. This was good experience in leaning on an interdisciplinary team for further expertise while also being able to solve the patient's immediate needs.

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

Transition to ostomy preceptor. Goal to perform site marking or gain experience with irrigation.

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	✓	

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• 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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