Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: H. Alexis Seris Espinal _____ Day/Date: 6/12/25_____

Number of Clinical Hours Today: 8____

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

Preceptor: Jennifer Brinkman_____

Clinical Focus: Wound X____ Ostomy ____ Continence X____

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 saw four patients today. All of the patients had moisture-associated skin damage to their coccyx and/or buttock region. Two of these patients had pressure injuries related to their MASD. Their conditions were related to immobility or not shifting/repositioning often in bed or when seated. Most patients were recommended a thin petroleum barrier cream or a more protective zinc oxide-based cream.

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.

Chart note:

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2

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Activity	1
Mobility	1
Nutrition	1
Friction/Shear	2
Total	9

Initial Assessment:

In to see a 67-year-old male for multiple wounds on the penile region, buttocks, coccyx, and lower abdomen per consultation order. Pt admitted to the CICU for cariogenic shock. PMH of HTN, HLD, DM Type 2, COPD, CAD s/p CABG, HF, AAA, and severe aortic stenosis. H&P reviewed, NKDA noted. Explained role and reason for the visit. Pt is unable to agree to visit, is currently intubated, sedated, and not responding to verbal stimuli. The primary RN and staff RN were present during visit.

Pt is currently NPO at this time.

Occipital is dry, intact, and blanchable.

Pt requires O2 therapy with ETT and holder in place. Tissues under the tube and holder as well as surrounding tissues are WNL. Silicone bordered foam dressings in place on cheeks. Bilateral Proximal creases of ears are dry, intact, and blanchable. Lips and inner mucosa dry, intact and blanchable.

Soft resistants in place. Removed to assess tissues under and surrounding restraints. Skin WNL at this time. Reapplied soft restraints.

Bilateral scapulas, pectoral girdle, elbows, trochanters, ischial tuberosities, patella, calcaneus, and medial/lateral malleoi are dry, intact, and blanchable.

Removed heel lift boots to assess BLE and reapplied following assessment.

Skin folds under breasts and groin, dry, intact, and blanchable.

Lower abdominal fold MASD: linear open moist aspects with irregular edges, pink/red blanchable erythema, with moist, intact, surrounding tissues. Not measured at this time as it extends to either side of the lower abdomen. Moderate amount of serous exudate. Cleansed with skin cleanser wipes. Pat dry. Applied moisture-wicking silver fabric dressing.

Foley 18 Fr in place. Penile meatus was cleansed with skin cleanser wipes. Intact skin noted, purulent exudate oozing around the catheter.

Coccyx extending distally into gluteal fold MASD: linear, open moist, pink, blanchable, with moist, intact surrounding tissues. Scant amount of serous exudate noted. Measured at 2cm x

0.3cm x 0.2cm in size. Area cleansed with skin cleanser wipes. Pat dry. Applied thin barrier cream.

R buttock stage 3 POA PI: irregular in shape, full thickness tissue loss, red, open moist, non-blanchable wound base with intact, blanchable erythema to surrounding tissues. Scant amount of serous exudate noted. Measured at 2cm x 0.5cm x 0.3cm in size. Cleansed with skin cleanser wipes. Pat dry. Applied thin barrier cream.

Pt able to turn side to side in bed with 3 assists. Pt INC of bowel, white absorptive chuck pad soiled at this time. Pericare performed by the primary RN and staff RN. Pt repositioned in bed to a semi-fowler position with turning wedges to the left side by this RN, Primary RN, and staff RN. Bed in low and locked position.

Pt on a low air loss mattress that is on and functioning.

Time spent with Pt 45 minutes with Jennifer Brinkman, MSN, APRN CNS CWOCN.

H. Alexis Seris Espinal BSN, RN WOC nursing student.

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)

1. Lower abdominal fold: Apply textile Ag single layer sheet. Allow for 2 to 3 in of overhang to wick moisture.
2. Coccyx, bilateral buttock, perianal, and surrounding tissues: Apply zinc oxide barrier cream BID and PRN for soilage.
3. Turn and reposition to maintain offloading of the coccyx/ischium Q 2 hours with the use of turning wedges.
4. Apply heel lift boots to bilateral heels for offloading. Remove Q shift to assess heels.
5. Maintain low air loss mattress while Pt is in ICU.
6. Obtain and apply low air loss bed pump when Pt is transferred out of ICU to a general medicine unit.
7. Nutrition consult for supplemental feedings while Pt remains NPO

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

This patient is immobile, sedated, moist, and at high risk for skin breakdown. The care provided has a key purpose of prevention. We wanted to prevent further breakdown due to pressure, moisture, and shearing. The use of barrier creams and preventive measures such as heel lift boots, turning and repositioning schedule, turning and repositioning wedges, and air loss mattresses will aid in the prevention of further skin breakdown.

An alternative to the treatment that could be used for the abdominal folds and coccyx/buttock MASD is the use of a hydrophilic paste. This may be followed by an ABD pad as a secondary dressing. The hydrophilic dressing would protect these wounds in difficult areas to keep a dressing and facilitate in autolytic debridement.

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 today was to identify different wounds and different types of debridement. Part of this goal was today achieved. We saw patients with MASD and some who developed pressure injuries from the MASD. I was able to differentiate the appearance of skin breakdown from moisture vs. pressure. This allowed me to understand that MASD puts the patient at higher risk for pressure-related skin breakdown. This also reminded me that old wounds with scar tissue formation are also susceptible to recurrent skin breakdown to that area. We did not go over many debridement methods as the goal for these patients was to protect and prevent further moisture via the use of skin barriers.

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

Tomorrow I would like to stoma site mark a patient and or assist with peristomal skin alterations.

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	✓	

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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	✓	

Reviewed by: _____ Date: _____

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