Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Erin Stewart Day/Date: July 8, 2025

Number of Clinical Hours Today: 8

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

Preceptor: Colleen Baisden

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.

I saw multiple patients today with my preceptor. A majority of the patients we saw had pressure injuries to their coccyx or close by. When seeing the patients we did education regarding what products we were using for their wound and why we were using that particular item for their wound. We also provided education about getting off of their bottom in order to offload that pressure that's been causing their wound.

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:

A 62-year-old male is being seen with the admitting diagnosis of non-rheumatic tricuspid valve insufficiency, and severe tricuspid regurgitation. The patient has a past medical history of diabetes, end-stage renal disease, coronary artery disease, congestive heart failure, transient ischemic attack, and non-ST elevation myocardial infarction. The patient was admitted with full-thickness wounds to his right inner thigh that are similar to what he has had before on his left lower leg, which was calciphylaxis. These wounds are being classified as a non-pressure ulcer. The patient states that he does follow with a wound clinic outpatient and was using Santyl

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to the area. These wounds have yellow slough in the wound bed with a moderate amount of serosanguinous drainage and no odor present. The patient denies any pain to these wounds at this time. The patient also states that the dressing order was very confusing, which is why he requested another consult to wound care to reassess the area. Dressing recommendations will be updated, and the new instructions were reviewed with the patient and the bedside RN. It is recommended that the patient follow up with the wound clinic/home health care outpatient to further manage and care for his wound/s upon discharge. Santyl, aquacel, and mepilex transfer had been being used to dress the wound, this was discontinued. The patient's wound was cleansed with normal saline then dried, vashe was used to saturate gauze which was applied to the wounds and allowed to sit on the wound for 5 minutes, then gently removed and dried the area. 3M skin barrier wand was applied to the peri-wound skin and allow to dry, then moistened Hydrofera Blue cut to fit wound and moistened was applied and covered with an ABD with a small amount of silicone tape to secure the ABD to the leg, a tubi-grip was then applied over top to secure the dressing.

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	3
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)

- To The right upper thigh (2 areas) – Remove the old dressing, cleanse wound with normal saline and then dry. Apply Vashe saturated gauze to the wound and allow to sit on the wound for 5 minutes, then gently remove and dry the area. Apply 3M Skin Barrier or ConvaTec skin barrier wand to the peri-wound skin and allow to dry. Then, apply moistened Hydrofera Blue cut to fit wound and cover with an ABD (a small amount of silicone tape may be used to secure the ABD to the leg) and then secure with a tubi-grip. Change every other day and as needed. If Hydrofera Blue turns from blue to white dressing needs to be changed. (Cut Hydrofera Blue while it is dry and then use NS to moisten before placing on the wound. Check the dressing daily and if the Hydrofera Blue has turned white or is very saturated change the dressing.

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- Monitor blood sugar and treat as advised.
- Increase protein intake within the limitations of diabetic and ESRD diet.
- Call wound care for any changes in the wound, or any wound dressing concerns.

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

The original wound care orders put in by another wound care nurse practitioner were confusing to the patient and to other nurses providing care. We changed to Hydrofera Blue in place of Santyl for debridement since Cleveland Clinic doesn't use Santyl as part of it's formulary. The Hydrofera Blue also took the place of the aquacel and mepilex transfer. The Hydrofera Blue was used in place of all of these to simplify the wound dressing but also because of it's antibacterial, debridement, and absorptive properties. Using an ABD pad over top will help prevent leaking of exudate from the wound. Using silicone tape and tubi-grips allows for the dressing to stay in place but also be gentle on skin. I would have recommended a consult with a dietician to be sure that the patient's nutritional needs for wound healing, diabetes, ESRD, and CHF are being met.

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 learn what happens during a day as an inpatient wound care nurse vs. how my day goes as a wound care nurse in the long-term care setting, and take in any and all tips and tricks I can bring back to and use in my wound care practice.

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

My goal for tomorrow is to learn about and see a more complicated wound patient so that I can learn and see how the wound assessment and treatment/plan of care changes based on the complexity of the wound.

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	✓	
• Includes pertinent PMH, HPI, current medications and labs	✓	

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• 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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