Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Jessica Whelen_____ Day/Date: 07/08/2025

Number of Clinical Hours Today: _8__

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

Preceptor: __Jennifer Brinkman____

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.

Today, with my preceptor we saw five patients that w~~h~~ere wound focused consults. Two patients had chronic wounds ~~i~~on the ischium. One had a leg injury that started as a hematoma. As the hematoma resolved, the wound evolved to have eschar. The other two wounds w~~h~~ere on the coccyx/sacral region unstageable, treatment included hydrogel and a non-adherent over lay and foam dressing. The patient with the left lower extremity, my preceptor chose to use hydro gel and foam dressing to cover. ?for? ~~I~~this care I would have asked for a vascular study to check the blood flow to her leg and a surgical consult, for potential debridement. Depending on her vascularity and if surgery decided if debridement was not necessary, for treatment I feel you could just leave the wound as is and allow to heal on its own, or use a enzymatic derider. Since I did not see this wound I cannot be prescriptive but generally leaving a wound to heal on its own defeats the purpose of our work. Our goal is to help wounds heal at their max rate as that helps to prevent infection & allows the patient to get back to their life w/o a 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:

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2

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Activity	1
Mobility	1
Nutrition	3
Friction/Shear	1
Total	10

This is the initial wound care consult note for a 41-year-old male, who is initial admitted for GI tube dislodgment. Per Epic, patient has a significant PMH of developmental delay, quadriplegia, seizure disorder, chronic respiratory failure, and neurogenic bladder with chronic urinary retention s/p supra pubic cathete r placement. Patient is also the tracheostomy and gastrostomy tube. Medications reviewed. Father is at bedside, who is the patient's primary caretaker, and provided pertinent patient information. Patient has home care services in the home. Patient was admitted with a coccyx and right ischium pressure injuries. The right ischial injury was first noted on 2/11/2025. [1]Treatment prior to admission included Calcium Alginate with Ag and Dakin's solution. Dressing is completed BID and as needed for soiling. Coccyx wound was noted on 6/3/2025, treatment prior to admission was an ~~a~~Allevyn foam dressing.
Patient is currently lying-in bed, appears to be sleeping, however responds to physical touch, and opens eyes when his name is called.
Skin assessment:
-Coccyx: healing stage 4 pressure injury. Foam dressing was removed, scant serous drainage noted. Wound was cleansed with normal saline. Wound measure 0.2 cm x 0.5 cm x 0.4 cm. Oval in shape, wound base is pink, wound edge is macerated, peri wound is moist. Skin prep applied to peri wound. Small strip of silver alginate was applied and covered with foam dressing.
-Left ischium: with evidence of healed ~~ulcer~~wound or PI, pink and blanchable, skin remodeling noted.
-Right ischium: healing stage 4 pressure injury. Foam dressing removed, packing removed, moderate amount of serosanguineous drainage noted. Wound was irrigated with 10 cc of normal saline. Wound measures 2 cm x 1 cm x 2.7 cm straight on depth. Tunneling is noted at the 12 o'clock of 8.7 cm and 3 o'clock of 5.8 cm. Bone is palpable. Wound edge is macerated, peri wound is moist, no odor noted. Skp~~p~~in prep was applied to peri skin, wound was lightly ~~packed~~ filled with moist gauze, covered with foam dressing at father's request. Patient tolerate procedure well, appeared to sleep through assessment and dressing change.
Education provided to patient's father about tu~~r~~ning and repositioning at home, and the importance of physical turning. Patient is nutritional optimize with g-tube feeding, would consider bulking agent to help with frequent stooling. Dad states he has no further questions, patient is potential for discharge today.

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)-this is not in past tense as you are writing orders for staff or family or home health nurse to follow

Coccyx: Cleanse~~d~~ with normal saline. Apply skin prep ~~applied~~ to peri wound. Insert small strip of silver alginate to coccyx wound cover~~ed~~ with foam dressing. Change dressing daily and as needed per soiling.

Right ischium: Irrigate~~d~~ wound with 10 cc of normal saline. Apply skin prep to peri skin, ~~wound was~~ lightly ~~packed~~ fill tunnel with normal saline moistened gauze, cover~~ed~~ with foam dressing. Change dressing daily

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and as needed, per soiling

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

Patients father is very involved with son's care and is looking to do what is optimal for patient in regard to healing. Therapeutic listening was provided, and time was allowed for dad to express concerned and ask questions. The wound did not appear to be infected, although it was reported by home care that purulent drainage was present as well as odor. I would be inclined to request a wound culture, since bone was palpated, I would also recommend r/o for osteomyelitis. Absolutely! **1. Did he have a surgical consult for this wound?** At this point if there is no evidence of osteo or if there is systemic treatment has been started, consider wound vac to assist with wound closure. Reasonable plan to use NPWT! Moist saline dressing is not the most effective dressing to use on a wound like this. Other items on which you can comment in this section if they are not done…What kind of info was gathered re support surface for bed in hosp. & at home? Is he up in chair? What kind of turning orders were there?
For your own practice think about the *whole* picture of the patient & the Braden subscales.

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?
Today's goal was to learn how my preceptor organizes the day, how patients are prioritized, become familiar with the facilities formulary.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
Complete clinical assessment of a patient's wound, state what I find in my assessment about the wound and how I would treat the wound and see if my preceptor would agree, if not give rationale.

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)	✓	✓

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• Statements direct care of the patient in the absence of the WOC nurse		somewhat
• Directives are written as nursing orders		✓
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter		Need bigger picture
• Identifies alternatives/what would have done differently		NPWT
Learning goal identified	✓	

Jessica, good first journal. Double check your spelling though as you should not make these errors in a medical record.
See comments above & use these comments when doing your next journal. If not NPWT, another dressing should be used for sure for that wound. If my comments do not make sense, lets talk!

Reviewed by: Patricia A. Slachta Date: 7/9/25