Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Theresa Farley Day/Date: Monday 7/14/25

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.

On this day, we began by reviewing Scout thermal imaging from the weekend. We then reviewed the charts of those newly admitted that required a wound care consult. The team reviews every consult request and then reviews the patients' chart and places the patients into a priority order and then these APRNs divide out the cases for the day, review cases assigned to them and then goes to the various units to see all patients. Today saw patients from 6 years old to 76 years old. There was a large variety of wounds to be seen, including cancerous lesions, radiation burns, extensive pressure injuries, diabetic foot ulcer, HSV to buttocks, and an unknown hemorrhagic bullae and skin sloughing in a patient with cancer that is now receiving intensive care. We completed assessments, reviewed treatments, selected new treatments, administered those treatments, and provided family, patient, and staff education for the each patient's treatment plan.

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:

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74-year-old female is seen at request of primary doctor for wound consult to vaginal/perineal area. Patient has a prior medical history of Type 2 DM, hypertension, hyperlipidemia, hypothyroidism, anxiety, and Stage IIIB Vulvar Squamous Cell Carcinoma, currently receiving Carboplatin/RT chemotherapy with last treatment on 7/7/25. Patient history of present illness includes admission to hospital from ED on 7/11/25. Patient went to radiation appointment where she was found to be tachypneic and tachycardic with c/o of SOB and pain to lower extremities. She was sent to the ED to rule out DVT and PE. Once admitted, patient began to complain of pain to perineal area.

Patient is seen lying in bed with no one at bedside and is being seen for a wound consult regarding perineal wound requested by hospitalist. She reports that the area is the location of her cancer and that she was receiving radiation treatments to the area. Patient states that she has only 3 radiation treatments remaining, and 'will be done in a week.' Radiation therapy has been placed on hold due to change in condition, but patient reports that she is eager to complete the course. She reports that pain is 'too much to stand' and that it hurts very bad when dressing the area. Patient was found in bed, wearing a brief, with rolled toilet paper applied to vaginal opening. She states she doesn't know how it got there. Patient reports she is able to provide own ADL care and lives independently in the community. Patient was medicated for pain prior to assessment and treatment.

Atypical fungating malignant wound on Left Labia Majora. Wound measures 3.5cm x 3.5cm x 0.1cm. Wound bed is red and yellow with moderate amount of serosanguineous exudate. Swelling noted throughout the perineal area. Perineal area is denuded, red, moist, friable, and painful, presenting as moist desquamation (radiation burns) that extend out from wound over mons pubis to bilateral inguinal folds and inner thighs. Odor is noted after cleaning. Radiation markers are present on mons pubis, and were not removed or disturbed for assessment. Area gently cleansed with normal saline to remove toilet paper and debris. Applied Vashe soaked gauze to entire perineal area and allowed to sit for 5 minutes. Gently removed gauze and applied Urgotul to areas presenting as radiation burns and Aquacel Ag to cancerous wound. Secured with mesh panties. Patient educated on importance of managing moisture, frequent repositioning, calling when assistance when toileting is needed, and a review of dressings and plan of care. Medline Comfort Glide sheet with wedges, low air loss mattress, heel protectors, and Critic-Aid cream ordered. Nutrition consulted to optimize wound healing.

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	1
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	2
Total	16

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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. Remove dressing gently. May soak with NS as needed to ease removal. Cleanse wound by gently applying Vashe soaked gauze to wound and periwound area. Allow gauze to sit for 5 minutes. Gently remove gauze and allow the area to dry. Apply Aquacel to cancerous wound on Left Labia Majora and apply Urgotul to periwound area to address radiation burns. May cover loosely with abd pads and then secure with mesh panties. Change twice a day and as needed for soilage, excess drainage, or dressing removal.
2. Contact WOC nurse for worsening wound, open areas, increased complaints of pain, signs of infection, increased drainage, purulent drainage, or if there are concerns that area is deteriorating.
3. Consult with Nutrition/Dietician to evaluate opportunities to optimize wound healing.
4. Isotour blower to be applied to bed for low air loss.
5. Turn and reposition every 2 hours using Medline Comfort Glide sheet with wedges.
6. Gently assist with cleaning after every episode of incontinence or self-toileting. Ensure no additional products are adhered to area and that area is clean and dry. Replacement of dressings may be needed. Apply light layer of Critic-Aid barrier cream to buttocks as a preventative due to increased moisture in the area.
7. Do not remove radiation markers on skin. Gently clean around and over areas.
8. Consult with PT/OT to evaluate options for increasing movement, promoting safe self-care, and preventing friction/shear.
9. Nursing to provide assistance and oversight of ADL care (showers, toileting) via 1 person assist. Patient states that shecan do these things but may need additional assistance during change in condition.
10. Work with Hospitalist, PCP, Medical Oncologist to manage pain. Nursing staff to encourage deep breathing, narrate care as it is provided, and allow patient time to prevent anxiety and pain.

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

The care provided today was personable, professional, and quality care. We saw several patients with a wide variety of wounds, and my preceptor really prioritized quality assessments and educating patients on the plan. It was great to take that time with each patient.

The one thing that I may do differently would be considering any option to best manage the pain for this patient. The radiation burns that we saw today were very similar to some of the excoriation seen with ostomies and significant/multiple fistulas. One of the products used for that very red, denuded, irritated skin was Domeboro. The skin seen on this patient was very similar to what was seen on prior patients where this product gave great relief. Domeboro could be used several times per day (2-4 times) as a means of providing

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comfort. Domeboro soaked gauze could be laid across the area for 15 minutes at a time, and this could be repeated throughout the day. Again, this may not be a technique for healing necessarily, but if it could provide pain relief and comfort, it may be worth trying.

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 was to have a better understanding of assessments and various etiologies. I certainly saw a large variety of etiologies today, and many of these were wound types that I would not typically see in my care setting. Even though I do not routinely see these types of wounds, they are a large part of what I have studied, so it is helpful to see. Today, I saw several atypical wounds.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
Tomorrow will be spent with the WCCT again. I was glad to be with the same specialty focus several days in a row. My goal for tomorrow is to see all that I can, and to work with my preceptor to work on making recommendations for treatments.

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	✓	

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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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