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: Tuesday, 7/15/25

Number of Clinical Hours Today: 8.0

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.

Charts were reviewed for patient encounters. Patients ranged from 52 to 85 today and included various etiologies. One patient was found in the home after several days sitting in a chair without moving. This resulted in DTIs to soles of feet both ischiums, extending to bilateral buttocks and thighs. We saw the use of Atrac-Tain cream to manage lipadermatosclerosis with venous wounds and compression wrapping. In this case, I also learned more about Unna boots, which the patient used prior to admission. I also saw surgical wounds, pressure injuries, and traumatic wounds, such as skin tears. Much time was spent providing patient education on these wounds, assessing, and selecting and applying treatments. We also discussed each plan of care with the nurses caring for the patients, and provided education as we went.

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:

Patient is a 62-year-old female with past medical history of ESRD, Hyperlipidemia, Hypertension, diverticulosis, GERD, and COPD not requiring oxygen. The history of present illness (wound) began when patient was seen for kidney transplant following a long history of ESRD. Surgery was performed on 5/14/25. On 6/26/25, she returned to the hospital with complaints of pain to abdominal incision, requiring surgical debridement of tissue in the surgical wound following dehiscence. The wound has been ongoing since that time.

Patient is seen today for wound consult at request of hospitalist for surgical wound that is not healing. Patient is alert, oriented x 3, has no one at bedside and reports that her family may visit later today. Vital signs reviewed and all within normal limits. Patient is alert, oriented, and able to move independently without assistance. Wound is present to lower abdomen, following Pfannenstiel incision. Wound bed is ruddy in appearance, red and yellow tissue, marbled appearance, and measures 1.5 cm x 8.5 cm x 3.9 cm. Edges are flat and open. No bone, bowels, or organs are visualized. The incision and wound are in the midst of an abdominal fold, making for difficult placement of dressings. There is a heavy amount of serious- exudate leaking onto periwound with a large amount of moisture noted. The periwound skin is intact, no discoloration, and is fully blanchable at present. Patient denies pain to area, though some grimacing is noted, and reports that she just wants the wound ‘to close.’ Patient received pain medication from bedside nurse approximately 1 hour prior.

Area surrounding wound cleansed with pH balanced foam cleanser and rinsed well with water. Area patted dry. Applied no-sting Esenta skin barrier to perimeter of wound. Wound bed lightly filled with 1 piece of black foam and 1 piece of black foam for placement of track pad to lower abdomen. Covered with transparent drape dressing. Track pad applied, and suction maintained at -100mmHg continuous low suction. Dressing compressed with suction and has no signs of leaks. Patient denies any pain, discomfort, or concerns. Educated on notifying nurses for loss of suction, loss of seal, discomfort, changes in output, bright red blood coming from area, foul odor, redness, warmth to area, alarming or strange sounds from the machine. Discussed risks/benefits of NPWT with patient and plan of care, patient verbalized understanding and stated ‘if this will help it to close, let’s do it.’

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	3
Mobility	3
Nutrition	4
Friction/Shear	2
Total	20

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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. Patient will notify nursing staff immediately for any alarms or different noises from wound vac, increased pain or pressure, loss of seal, bright red blood in cannister, signs or symptoms of infection (increased temperature, erythema to area, warmth, purulent drainage), or allergic reaction.
2. Notify provider/WOC if there are signs of infection, increased pain, pressure, loss of seal that cannot be restored, bright red blood is present in the cannister, or there is significant change in the quality or quantity of drainage.
3. Check dressing to make sure seal remains intact after transferring, ambulating, or repositioning (foam should remain collapsed, no tears in the clear dressing, no abnormal sounds from machine).
4. Avoid taking baths with machine present. Sponge baths and bath wipes are acceptable.
5. Continue to manage pain, chronic conditions, and transplant follow up with PCP.
6. Document total number of foam pieces placed in wound with every dressing change. Note the number of foam pieces on the dressing with the date and in a progress note.
7. Prior to dressing change, gather supplies. Cut pieces of foam to template in an area away from the wound bed (do not cut foam while holding over the wound bed).
8. For NPWT Change: Gently remove dressing. May moisten black foam with NS to aid in removal, if needed. Cross-check that all pieces of foam documented have been removed. Cleanse wound with Coloplast Sea-Clens Wound Cleanser. Dry surrounding skin with gauze. Apply Esenta Skin barrier around the periwound where the drape will be placed. Cut foam piece to fit wound bed. May use a template as needed. Cover with transparent drape. Cut a small hole (approximately 1-2 cm) in the drape and apply the track pad aligning with this area. Connect to the V.A.C. Unit and set to -100 mmHg continuous per provider order. Observe for no leaks and draw down of dressing/foam.
9. Check canister for drainage every shift and document amount of drainage in EMR.

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

Today was the final day with the WCCT. This was a very interesting experience, and I was glad to have these days back-to-back with the same preceptor. The care provided aligned with the patient's goals of achieving closure. The only change that I think may have been helpful would be to have family at bedside to be a part of the discussion and education. This is a key part of making sure that there is and can be compliance. Patient was alert/oriented x3, so she was capable of making this decision, but I do think it would have been helpful to have more info. I was surprised to learn that the WCCT does not typically manage the wound vacs, and that this is overseen by the ostomy team and this patient would no longer be on the case list for WCCT.

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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 spend additional time really doing assessments, reviewing wounds, and selecting treatments. Today, we were able to see some additional types of wounds, as well as some different types of treatments and that has been very helpful. My goal was to really spend some time discussing with my preceptor the nuances around identifying etiology and that was achieved.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) Tomorrow will be spent in the manometry office and with Dr. Spivak. My goal for tomorrow is to have a better understanding of colorectal and urinary conditions and to better understand the treatment options that are available.

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	✓	
• 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	✓	

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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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