Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __Maria Fe Briones_____ Day/Date: __7/15/25_____

Number of Clinical Hours Today: ___8__

Care Setting: Hospital ___/__ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: ____Kimberly Blasiole, APRN_____

Clinical Focus: Wound __/__ 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, I encountered a diverse range of patients with various wound types and clinical needs. Cases included surgical wounds, diabetic foot ulcers, pressure injuries, and wounds resulting from shear and friction. Most patients were awake, alert, and responsive. Mobility levels varied significantly: some patients were immobile and bedridden, others required walkers or assistance for ambulation, and a few had lower limb amputations impacting their mobility and wound care needs. These encounters highlighted the complexity of wound management across different patient populations, emphasizing the importance of individualized assessment and care planning. **1. How many patients did you see today?**

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:

Mary Mack is a 69-year-old African American female who presented to the ED on 7/4/25 with worsening shortness of breath. She reports nonadherence to her prescribed medications due to insurance issues and recent changes in her medications. She describes progressive dyspnea over several days, which prompted her ED visit. Her medical history is significant for chronic heart failure with reduced ejection fraction (EF 45%), coronary artery disease with a history of LAD stent placement in 2013, hypertension, stage 3 chronic kidney

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disease, hyperlipidemia, anxiety, peripheral vascular disease (PVD), and type 2 diabetes mellitus. She also has a history of left leg deep vein thrombosis and is currently on Eliquis. Her PVD history is notable for a left lower extremity above-knee femoral-popliteal bypass using a reversed saphenous vein and left hallux amputation for gangrene (completed antibiotics on 6/23). She also had a right below-knee amputation performed in 2022. She was recently discharged from Summa Hospital on 6/30 after treatment for gangrene, decompensated heart failure, and the recent bypass surgery. She continues to smoke cigarettes daily. The patient's laboratory results show anemia (Hgb 9.1 g/dL, Hct 29.2%), which may be related to chronic disease, renal insufficiency, or recent surgical blood loss. Hypoalbuminemia (3.2 g/dL) suggests a poor nutritional status, which can impair wound healing. Elevated creatinine (1.74 mg/dL) is consistent with her known CKD stage 3, further complicating wound healing potential. Random glucose is elevated at 162 mg/dL, indicating suboptimal diabetes control and known type 2 DM, a critical factor in the development and persistence of diabetic foot ulcers. Urinalysis with +1 protein is suggestive of diabetic nephropathy and with CKD stage 3. Together, these findings highlight her elevated risk for poor wound healing due to diabetes, chronic kidney disease, malnutrition, and ongoing tobacco use. This underscores the importance of today's follow-up wound care visit to reassess her diabetic foot ulcer, monitor for signs of infection or poor perfusion, and coordinate a multidisciplinary plan to support wound healing and limb preservation. This follow-up was conducted with Kimberly Blasiole, APRN, and Sally Pyle, Wound/Ostomy RN. The patient is alert and oriented, lying comfortably in bed without shortness of breath. Vital signs stable: BP 131/83 mmHg, Pulse 76 bpm, Respirations 18/min on room air with O2 saturation 95%, Temperature 36.3 °C. The cardiovascular exam is notable for palpable pedal pulses in the left foot with the right lower extremity with below-knee amputation. An open wound was observed on the left medial foot; the left heel was intact without breakdown. The surgical incision on the left medial leg is well approximated without signs of dehiscence or infection. Coccyx and buttocks skin intact without evidence of pressure injury. The open wound on the left medial foot is consistent with a diabetic foot ulcer present on admission. The wound bed exhibits yellow slough, the peri-wound skin is intact, and the wound is oval-shaped, measuring approximately 8 cm in length and 4.5 cm in width, with moderate yellow-tan drainage. The wound was cleansed with wound cleanser, treated with Mesalt and 1% Silvadene cream, and then covered with gauze and Kerlix; the dressing needs to be changed daily and as needed. The coccyx area was protected with Allevyn foam dressing, scheduled to be changed every 3 days or PRN if soiled, with instructions to peel back the dressing each shift to assess underlying skin. The patient was educated and assisted with turning and repositioning every 2 hours or instructed to self-turn every 2 hours, with heels offloaded using boots or pillows to prevent pressure injury. **A referral to a dietitian is crucial given the patient's lab results suggesting possible malnutrition. It is also important to communicate with the primary team to achieve better blood sugar control. Additionally, smoking cessation support should be prioritized to promote overall healing and reduce the risk of further complications**. You just need to do these things & chart them as done vs. speculating in your note because then if it is not done & there are problems you had put it in writing. The patient was cooperative during the assessment. She engaged in a discussion about her wound care plan and expressed an understanding of the need for close monitoring of her wound. Education was provided on wound care, smoking cessation, and the importance of glycemic control. The wound site was assessed for signs of infection or poor perfusion. The plan for ongoing multidisciplinary follow-up was reviewed with the patient, who voiced agreement with the care plan. Products used during this encounter included Sea-Cleanse wound cleanser, Mesalt (sodium chloride–impregnated dressing), 1% Silvadene cream, sterile gauze, Kerlix wrap, and Allevyn foam dressing. Much better note

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Braden Risk Assessment Tool

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

The patient's Braden Score is 16, which indicates **mild risk** for pressure injury development according to the Braden Risk Assessment Tool. This score suggests that, despite having some risk factors, the patient may still exhibit relatively good sensory perception, **moisture control, activity**, mobility, nutrition, and overall **friction/shear** management. Anything w a score of 2 or less should have a definitive plan However, preventive measures are still important, including regular repositioning, skin inspections, moisture management, and the use of support surfaces to reduce the risk of skin breakdown.

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)

Wound Location: Left Medial Diabetic Foot Ulcer:

- Cleanse wound with Sea-Cleanse wound cleanser.
- Apply 1% Silvadene cream and Mesalt (sodium chloride–impregnated dressing) to wound bed.
- Cover with sterile gauze and secure with Kerlix wrap.
- Change dressing daily and PRN if soiled.
- Reposition and turn patient every 2 hours.
- Offload heels using boots or pillows to prevent pressure injury.

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

The current wound care plan for the left medial diabetic foot ulcer is appropriate, focusing on thorough cleansing, application of antimicrobial and moisture-absorbing dressings, and proper dressing techniques. The inclusion of regular dressing changes and offloading strategies addresses both infection control and pressure relief, which are critical for wound healing in diabetic patients. OK but also consider being specific in your repositioning plans, how often should boots be removed, and how are you preventing friction & shear? Even tho you are the wound nurse, you do need to think of the big picture related to skin & wound.

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?

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Today's goal was partially met, as I was able to clearly visualize and assess the presence of slough on the wound bed. The patient appears to be an appropriate candidate for debridement; however, coordination with the vascular team is necessary to confirm adequate perfusion to the affected area prior to proceeding with the intervention.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) To enhance my ability to accurately identify wound etiology and stage wounds, select appropriate dressings based on wound characteristics.

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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	✓	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	

Reviewed by: <u>Patricia A. Slachta</u> Date: <u>7/16/25</u>

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