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: ___7/14/25_____

Number of Clinical Hours Today: __8__

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

Preceptor: Kimberly Blasiole_____

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.

My patient encounters are primarily in an inpatient setting, where the focus is on managing both acute and chronic wounds that require ongoing treatment, close monitoring, and documentation of healing progress. The patients I see are typically coherent and responsive, and only one is nonverbal/nonresponsive. Many are recovering from surgical or orthopedic procedures and present with complex wounds, including postoperative incisions, pressure injuries, and traumatic wounds. These patients often require frequent wound care visits to ensure proper dressing changes, assess wound characteristics such as size, tissue type, exudate, edges, and peri-wound skin, and identify early signs of complications or infection, as well as select the appropriate wound dressing. **1. Maria, please rewrite this section about the patients that you saw on Monday** w the preceptor. We are looking for a brief description of the different types of patients seen and how many patients you saw. Today, I saw a total of 8 patients alongside my preceptor in the inpatient setting. The cases varied in complexity and included the following: pressure injuries, a skin tear, a postoperative lumbar surgical site complicated by purulent drainage, a diabetic foot ulcer, and a peristomal moisture-associated skin damage. We also followed up on a patient with a wound VAC in place, performing a dressing change. The majority of the patients were alert and responsive, with only one being nonverbal and nonresponsive. Most were recovering from surgical or orthopedic procedures and presented with complex wounds (pressure injuries) that required close monitoring, routine dressing changes, and thorough documentation. Each encounter focused on assessing wound size, tissue type, exudate, wound edges, and peri-wound skin condition to guide appropriate dressing selection and identify any early signs of infection or delayed healing.

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:

Mr. David Galehouse is a 74-year-old male who was admitted to the hospital on 7/11/2025 following transfer from a skilled nursing facility for evaluation and management of shortness of breath. He has a complex medical history, including seizure disorder with status epilepticus, traumatic brain injury–related epilepsy secondary to a childhood motor vehicle accident, dementia, hypothyroidism, depression, hypotension, unspecified psychosis, and prior deep vein thrombosis. He hais a tracheostomy- and PEG-tube-dependent, receiving tube feedings via PEG, and currently on a trach collar on 10 L. He is nonverbal and nonresponsive at baseline, with ongoing EEG monitoring to assess for seizure activity. Today's visit was conducted with Kimberly Blasiole, Wound/Ostomy APRN for ongoing wound care needs and treatment during the patient's inpatient stay. The patient has two identified wound sites upon admission, with a Braden score of 8. The first wound is a Stage 2 pressure injury located on the coccyx (gluteal cleft), characterized by a red wound bed with partial-thickness skin loss. It is oval, measuring approximately 2.1 cm in length and 0.4 cm in width, with a wound depth of 0.2 cm and a calculated surface area of about 0.84 cm^2. The peri-wound skin is excoriated, with scant red drainage noted, with no odor detected. The wound care plan for this wound is to cleanse the wound with wound cleanser at each dressing change, lightly pack the wound bed with Mesalt, cover it with a foam dressing, and change the dressing BID and PRN. What would you write in your own note at your place of employment? Do you just do a general note about the dressing or do you write specifics? This often depends on what kind of dressing orders are written.

The second wound is located on the bilateral buttocks and is consistent with irritant contact moisture-associated dermatitis. This area presents with irregularly distributed, scattered superficial ulcerations and widespread peri-wound excoriation. Drainage is scant and serosanguinous, with no odor noted. since you write a plan then your note could say Area cleansed and barrier ointment applied. If you turned the patient then you can write that note…patient turned on left side & pillows placed. Heel boots reapplied The wound care plan includes cleaning the affected area with wound cleanser and allowing the area to dry thoroughly before applying topical treatment. Apply zinc oxide cream to wounds located on bilateral buttocks BID and PRN. Pressure injury prevention includes turning and repositioning the patient every 2 hours, offloading heels with boots or pillows, and ensuring the patient is currently wearing heel boots. **Implement moisture management strategies, including prompt cleansing and the use of barrier creams, to protect against incontinence-associated dermatitis and maceration.** This is a plan not a note

Given the patient's PEG tube feeding, a dietitian consult in your own practice just make the consult is recommended to ensure adequate caloric and protein intake to support wound healing, with a review and adjustment of the enteral feeding regimen as needed. Maintain the tracheostomy site according to respiratory

~~care protocol to prevent skin breakdown or infection. Coordinate closely with nursing, nutrition, respiratory therapy, and the primary team to reinforce this comprehensive prevention plan and ensure consistent, interdisciplinary implementation.~~ Patient recent labs leukocytosis of WBC- 16.07, Hgb-11.2, Hct-35.7, MCV- 107.7, albumin -2.4, Na- 137, K-4.1, Mg- 2.1, Crea- 0.56, BUN- 25, AST- 32, ALT- 22, glucose- 128, Hgb AIC- 5.3. We interact with the patient by introducing ourselves by name, clearly stating the purpose of the visit, and explaining each step of care, including asking permission before repositioning or turning, even though the patient is nonverbal and nonresponsive. No family members were present at the bedside during the visit; however, a bedside nurse was present and provided education on the wound assessment findings, the current treatment plan, and ongoing care instructions. The nurse verbalized understanding. The specific products used during this encounter are Sea Cleanse Wound Cleanser, Allevyn Foam Dressing, and Zinc Oxide Cream.

Sensory Perception	1
Moisture	1
Activity	1
Mobility	1
Nutrition	3
Friction/Shear	1
Total	8

Braden Score of 8 (Based on Braden Risk Assessment Tool): A score of 8 indicates **severe risk** for pressure injury development. This reflects significant impairment in multiple areas assessed by the tool, including sensory perception, moisture, activity, mobility, nutrition, and friction/shear. Patients with this score require intensive preventive measures such as frequent repositioning, specialized support surfaces, meticulous skin care, moisture management, and nutritional support to reduce the risk of pressure injuries.

These are the nursing orders. Can be much shorter in the actual note

Wound #1- Coccyx stage 2- gluteal cleft- wash/cleanse wound with sea cleanse wound cleanser
-lightly pack gluteal cleft wound with Mesalt
-cover with Allevyn foam dressing
-change dressing BID and PRN

Wound #2 – Moisture Associated Dermatitis- Bilateral Buttocks –
-cleanse wound with sea cleanse wound cleanser
-dry thoroughly
-apply Zinc oxide cream BID and PRN

Turn and reposition Q2 hours
Offload heels with boots or pillows

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.

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WOC Plan of Care (include specific products)

Wound #1- Coccyx stage 2- gluteal cleft- wash/cleanse wound with sea cleanse wound cleanser
-lightly ~~pack~~ fill gluteal cleft wound with Mesalt
-cover with Allevyn foam dressing
-change dressing BID and PRN

Consider changing pack to fill in your practice as pack is sometimes misconstrued.

Wound #2 – Moisture Associated Dermatitis- Bilateral Buttocks –
-cleanse ~~wound~~ area with sea cleanse wound cleanser
-dry thoroughly
-apply Zinc oxide cream BID and PRN

Turn and reposition Q2 hours be more specific in your orders. For instance, do you want the pt on their back or should the repositioning be left/right?

Offload heels with boots or pillows pick one of these…& for most situations the boots are better

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

Today, wound cleanser was dabbed onto the wound instead of sprayed. I considered whether spraying wound have been more effective for mechanical debridement. I'm unsure if its appropriate for all cases. This highlighted the importance of choosing wound care techniques based on individual wound needs. ok good thought here. We want you to think about what else could be done for the patient in this section based on the info you learned in class. **2. What else could be done for the PI & the MASD?**

Patients with moisture-associated skin damage (MASD) typically experience persistent symptoms, including pain, burning, and itching. The skin exhibited partial-thickness breakdown and areas of denudation due to prolonged exposure to moisture. I reflected on the importance of being gentle when cleaning this type of wound. Using a wound cleanser with a light dabbing motion, rather than rubbing or spraying, can help prevent further irritation and help avoid adding more pain and discomfort to the patient. I also recognized that when moist skin is subjected to friction, it becomes more fragile and prone to further breakdown. For pressure injuries, the choice between spraying and dabbing wound cleanser depends on the condition of the wound. Spraying is generally preferred when the wound has moderate to heavy slough and drainage and needs light mechanical cleansing to flush out bacteria and loosen exudate without touching the wound, and the patient can tolerate mild pressure. On the other hand, dabbing is more effective when the wound bed has fragile granulation tissue, is very painful, or if the skin around the wound is already irritated. Always assess the tissue type, amount of exudate, patient pain level, and skin integrity.

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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

Goal met as I can be able to shadow and assist in managing complex wound cases by applying foundation wound care knowledge and techniques effectively.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) To observe and understand the procedure and clinical decision making involved in sharp wound debridement.

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	✓	
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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