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: ___7/16/25_____

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, we saw 7 patients with the preceptor. The lower number was due to an opportunity to visit the Hyperbaric Oxygen (HBO) unit, where I observed 2 patients receiving treatment and learned more about HBO therapy. As this was my first time seeing it in practice, it was a valuable learning experience. We also followed up on a patient with a wound VAC, and I had the chance to assist with the dressing change. This hands-on experience helped build my confidence in managing VAC therapy. The patients we saw presented with various wound types, including pressure injuries, burns, MASD, device-related pressure injuries, skin tears, and arterial and venous ulcers. Each case reinforced my wound assessment skills and the importance of individualized care.

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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Linda McKitrick is a 76-year-old female admitted with a 2-week history of shortness of breath, dry cough, wheezing, poor appetite, nausea, and vomiting. Her medical history is significant for hypothyroidism, obstructive sleep apnea (OSA), hypertension, GERD, depression, asthma, anxiety, anemia, ankylosing spondylitis, and rheumatoid arthritis (RA). She sustained a left hip fracture due to a fall on May 21 while in rehab. Recent labs showed Hgb 7.3, WBC 6.79, lactate 1.1, glucose 61, calcium 7.7, total protein 4.7, albumin 2.3, total bilirubin 1.2, and BNP 2211. These findings indicate anemia, hypoglycemia, poor nutritional status, and a markedly elevated BNP level, which may suggest fluid overload or underlying cardiac dysfunction. The patient is being seen today for a follow-up visit to reassess multiple skin and wound sites. These include a venous ulcer located on the left anterior ankle, a small open area along the incision site on the right below-knee amputation (BKA), moisture-associated skin damage (MASD) present on both groins, and deep tissue pressure injuries (DTPI) identified across the bilateral buttocks and sacral area. Each wound was evaluated for changes in appearance, drainage, healing progress, and the need for a dressing change. On physical assessment, the patient is alert and oriented to person, place, and time. She denies shortness of breath, fever, or chills. She reports wound pain on the left lower leg, describing it as throbbing and uncomfortable, particularly with movement, and rates it at 5/10. Pain medication was administered by the RN recently. The left lower leg shows pallor, +3 pitting edema, and a weak dorsalis pedis pulse. The patient denies nausea and vomiting. Skin assessment reveals dry, fragile skin with areas of breakdown as previously noted. She denies nausea and vomiting. No signs of acute distress were observed during the evaluation. The patient presents with multiple chronic conditions contributing to poor wound healing, including anemia, malnutrition, and possible fluid overload. Wounds remain open with varying degrees of severity. Pain is localized and manageable. The patient is alert and stable, with dry, fragile skin. Continued wound care, nutritional support, and pressure injury prevention are essential. The specific wound care products used include Xeroform dressing, zinc oxide topical cream, Allevyn foam dressing, Mesalt (sodium chloride–impregnated dressing), Sea-Clens wound cleanser, and Miconazole 2% topical cream. Interventions for Linda McKitrick should focus on optimizing wound healing through nutritional support, edema management, appropriate wound care, and the prevention of pressure injuries. Due to her low albumin, total protein, and hemoglobin levels, refer her to a dietitian to initiate a high-protein, high-calorie diet with necessary supplements, such as vitamin C, zinc, and iron. Her elevated BNP indicates possible fluid overload, so caution is advised when using compression therapy; instead, elevation of the lower extremities and collaboration with the primary team or cardiology may help manage fluid status. Wound care should continue with appropriate dressings, including Xeroform for the venous ulcer, Mesalt for the exudative BKA incision, zinc oxide and miconazole cream for groin moisture-associated skin damage, and Allevyn foam for the deep tissue pressure injuries on the buttocks and sacrum. Repositioning the patient every two hours, alternating between left and right, and back, and using pressure-relieving devices, such as heel boots and a low-air-loss mattress, is essential. Pain should be managed effectively prior to dressing changes, and the skin should be inspected every shift for any new breakdown or infection.

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Braden Risk Assessment Tool

Sensory Perception	4
Moisture	2
Activity	1
Mobility	1
Nutrition	2
Friction/Shear	1
Total	11

A Braden Score of 11 indicates that the patient is **at high risk** for developing a pressure injury and requires an aggressive prevention plan. Reposition at least every 2 hours and use pressure-reducing surfaces (specialty mattresses, cushions, heel offloading devices) to reduce sustained pressure. Keep skin clean, dry, and protected with moisture barriers; manage incontinence promptly and minimize friction and shear during transfers. Assess nutrition (protein, calories, hydration) and involve a dietitian if needed to support tissue repair. Perform and document daily skin checks—especially over bony areas—to catch early changes. Educate staff, patients, and caregivers so that prevention measures are consistently followed.

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 # 1 - Venous Ulcer Left Anterior Ankle

1. Cleanse the wound using Sea Clens Wound Cleanser
2. Cover the wound bed with 1 layer of Xeroform.
3. Cover with gauze and wrap it with Kerlix
4. Change dressing daily and as needed

Wound # 2 - Right, AKA small open area along incision site

1. Cleanse the wound using Sea Clens Wound Cleanser
2. Apply Mesalt (sodium chloride impregnated) to fit the open wound
3. Secure with a foam dressing
4. change dressing BID and as needed

Wound # 3 Moisture-Associated Skin Damage on Bilateral Groin

1. Gently dab the area with Sea Clens wound cleanser
2. Apply Miconazole topical cream 2% on the affected area
3. Apply cream BID

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4. Open to air

Wound # 4 - Deep Tissue Injury across bilateral Buttocks

1. Cleanse the wound using Sea Clens Wound Cleanser.
2. Apply Zinc cream to the Bilateral Buttocks BID and PRN.
3. Apply Allevyn foam dressing every 3 days and PRN if soiled or non-adherent. Peel back the dressing after each shift to assess the skin underneath.

Wound # 5 - Deep Tissue Injury on the Sacrum

1. Cleanse the wound using Sea Clens Wound Cleanser.
2. Apply Allevyn foam dressing every 3 days and PRN if soiled or non-adherent. Peel back the dressing after each shift to assess the skin underneath.

* Reposition the patient every 2 hours: turn to the **left side** for 2 hours, then to the **right side** for 2 hours, followed by the **supine (back) position** for 2 hours. Continue this rotation to reduce pressure and promote skin integrity.
* Offload the heels using heel boots, and assess the skin at least every 8 hours for signs of pressure, redness, or breakdown. During each assessment, remove the boots briefly to allow the skin to rest and put it back all the time.

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

The wound care provided appears appropriate and follows evidence-based practice, with proper use of cleansers, dressings, and topical agents tailored to each wound type. Repositioning every 2 hours alternating to left, right and back and heel offloading with scheduled assessments are essential and correctly implemented.

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?

Yes, my goal was met. I had the opportunity to assist with a wound VAC dressing change, which helped build my confidence and practical skills. Additionally, I visited the Hyperbaric Oxygen (HBO) unit for the first time, where I observed a patient undergoing treatment and received valuable education on its role in wound

healing.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)

Tomorrow, I aim to enhance my wound assessment skills by accurately identifying different wound types and staging pressure injuries. I also hope to become more confident in selecting appropriate dressings based on wound characteristics and patient needs.

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)	✓	
• 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	✓	

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Reviewed by: _____ Date: _____

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