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: __7/17/25_____

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.

I had the opportunity today to participate in the care of 10 patients with diverse wound and skin conditions**.** These included stage 2 and 3 pressure injuries, moisture-associated skin damage (MASD), abrasions, skin tears, and unstageable pressure injuries. I also observed complex cases such as a pseudo-stoma, paracentesis site with active drainage, and an open surgical wound in a patient with an ostomy. These patient encounters exposed me to a wide range of clinical scenarios—surgical, trauma-related, and pressure-induced wounds. The experience enhanced my understanding of wound etiology, deepened my appreciation for comprehensive skin assessments, and reinforced the importance of selecting appropriate dressings and individualizing wound care strategies. It was a meaningful and enriching day of learning.

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: D. M. is a 69-year-old female who presented to the hospital with abdominal pain and concerns of infection at the paracentesis drain site. The patient reports several days of redness, along with purulent and bloody drainage from the site. She has been diagnosed with sepsis, abdominal wall cellulitis, and acute kidney injury. Her past medical history is significant for type 2 diabetes mellitus, gastroesophageal reflux disease, hypertension, hyperlipidemia, obstructive sleep apnea, adenomatous colon polyps, diverticulosis, hiatal hernia,

irritable bowel syndrome (IBS), abdominal lipoma or mass, and depression. Wound care was consulted for evaluation of the heavily draining and redness on the paracentesis site. Upon assessment, the patient was alert and oriented with no signs of acute distress. She denied shortness of breath but reported localized throbbing pain at the drain site, rated 4/10. Pain medication had been administered 45 minutes prior by nursing staff. The abdomen was distended and firm on palpation, with scant, light yellow drainage, with pink peri wound noted, active bowel sounds, and the ability to pass gas. Additional findings included a traumatic skin tear on the left arm, noted red and ecchymotic peri wound, with scant serosanguinous drainage; contact dermatitis on the bilateral groin appears pink with moist peri wound and within skin folds, a Stage 1 pressure injury on the sacrum with intact peri wound-pink/red in color, non-blanchable erythema with intact skin, and a diabetic heel ulcer on the right posterior area with pink peri wound, oval in shape, with length of 0.7 cm, width of 1 cm, wound surface of 0.7 cm, draining scant serous which were all wounds are present upon admission. Vital signs**:** BP 118/68, HR 75, Temp 36.7°C, RR 16, SpO_2 97% on room air. Recent labs: Hgb 12.8, Hct 38.3, WBC 8.05, Lactate 3.3, K^+ 4.3, Na^+ 128, Mg^{2+} 1.9, Creatinine 1.28, BUN 29, Glucose 361, AST 28, ALT 23. I am not sure why you are writing in future tense as the note is a record of what was done to the pt & can be in more general terms if plan of care is going to be the same. The drainage site ~~should be~~was cleansed using a non-cytotoxic wound cleanser to avoid further irritation or tissue damage. An appropriate absorptive dressing, such as Allevyn or an ABD pad with an antimicrobial barrier, should be applied to manage the drainage and reduce the risk of infection . no, tell us what YOU did **1. What did you use here?** ~~The site must be monitored daily for drainage amount, color, and odor to detect any changes that may indicate worsening infection~~.We used gauze and cover it with ABD ~~Daily reassessment is essential to observe for signs of spreading erythema, fluctuance, or increased drainage. Coordination with the primary care team is important to ensure prompt antibiotic administration and appropriate fluid and electrolyte management. Glycemic control should be encouraged, as uncontrolled hyperglycemia can significantly impair the wound healing process. Regularly reposition and turn every 2 hours, alternating between the left side, right side, and supine position. Wear heel boots at all times while in bed. Lastly,~~ patient education given ~~should focus~~ on recognizing signs of worsening infection and maintaining hygiene around the drainage site to support recovery and prevent complications. The wound care regimen and the specific products used included Sea-Clens wound cleanser for gentle cleansing of all wound sites. For the abdominal site, where drainage was scant, fluffed gauze and an ABD pad were applied to provide gentle absorption and protection. This dressing choice helps manage minimal exudate while maintaining a clean and secure environment around the abdomen. Xeroform and foam dressings were used on the diabetic foot ulcer and skin tear to maintain a moist wound environment and support healing while preventing infection. Miconazole 2% topical powder was applied to the groin area to treat irritant contact dermatitis, addressing moisture-associated fungal involvement. A foam dressing was placed over the Stage 1 sacral pressure injury to provide a protective barrier and reduce the risk of further skin breakdown.

Braden Risk Assessment Tool

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

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A Braden score of 16 falls within the mild risk category (typically 15–18), suggesting that while the patient does not currently present a high risk, there is still potential for skin breakdown, particularly if their condition changes. As a preventive measure, it is important to initiate basic skin care interventions, such as frequent repositioning, maintaining clean and dry skin, ensuring adequate nutritional intake, and using pressure-relieving devices when appropriate. Ongoing assessment and early intervention are key to preventing pressure injury development in patients with a Braden score in this range.

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 - Irritant Contact Dermatitis - Left Anterior Groin
1. Clean the area gently with Sea Clens wound cleanser
2. Apply Miconazole 2% topical powder BID to the affected area

Wound # 2 - Traumatic Skin Tear - Left Lower Posterior Arm
1. Clean the area gently with Sea Clens wound cleanser
2. Apply 1 layer of Xeroform to cover the wound bed
3. Change dressing daily and PRN if soiled or non-adherent.

Wound # 3- Surgical - Left Lower Abdomen
1. Clean the area with Sea Clens wound cleanser
2. Apply fluffed gauze to the abdomen and cover it with ABD and secure it with paper tape.
3. Change dressing BID and PRN if soiled or non-adherent

Wound # 4 - Sacrum Pressure Injury stage 1
1. Clean the area gently with Sea Clens with wound cleanser
2. Apply Allevyn foam dressing every 3 days and PRN. Peel back the dressing each shift to assess the skin underneath.

Wound # 5 - Diabetic Foot Ulcer - Right Posterior
1. Clean the area gently with Sea Clens wound cleanser.
2. Apply 1 layer of Xeroform to the wound bed and secure with an Allevyn foam dressing
3. Change dressing daily and PRN

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

I found it comprehensive and tailored appropriately to each wound type. The use of Sea Clens wound cleanser for all wounds is appropriate for gentle, non-cytotoxic cleansing. Ok
I appreciate the targeted treatment for the Irritant Contact Dermatitis using Miconazole 2% powder, which addresses possible fungal involvement due to moisture in the groin area. Yes but what is causing this moisture? Causation should be the first factor addressed. If you have access to Interdry AG that might be more appropriate here (esp. if you do not know if this is fungal). For traumatic skin tears, Xeroform is a suitable choice for maintaining a moist wound environment, preventing infection, and promoting wound healing. Xeroform actually can dry out very quickly so is not the best option – depending on the size of **2.What else could you use?**-The surgical wound on the left lower abdomen, which has scanted serous exudate, was covered with fluffed gauze and an ABD pad. If this has scant drainage, absorption is not the key but keeping the wound bed moist is a goal so dry gauze & an ABD is not best practice-

3.What else could be used

1. For skin tears, other dressing options include nonadherent dressings, such as nonadhesive foam change every 3 days and as needed secured with wrap or roll gauze, nonadherent contact layers secured with wrap or roll gauze, impregnated mesh, silicone mesh, hydrogel, alginate, hydrofiber, and clear acrylic dressings, as well as those with gentle adhesive properties and use a protective sleeve.
2. [1.] For surgical wound with scant exudate, hydrogels may be the most appropriate option, change dressing every 3 days and as needed.

For the Stage 1 sacral pressure injury, the use of Allevyn foam with inspection each shift is appropriate. As a student, these experiences reinforced the importance of individualized care, skin protection, and ongoing wound reassessment.

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 for the day was to enhance my hands-on skills in wound care and expand my knowledge of advanced wound management technologies. This goal was met, as I was able to actively participate in dressing changes and observe wound assessments across a range of etiologies, including pressure injuries, skin tears, and surgical wounds. During the day, the preceptors and other staff provided valuable education on different dressing types and their specific indications, helping us understand the clinical reasoning behind product selection. These experiences reinforced key wound care principles and improved my clinical confidence in providing individualized care.

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

My learning goal for tomorrow is to continue building confidence in wound assessment and selecting appropriate dressings. I also aim to observe various debridement techniques, if the opportunity arises. Additionally, I hope to witness the application of the Prevena wound VAC dressing, as well as the VAC peel and place dressing, as this is a newer approach to wound vac dressing, to broaden my knowledge of advanced wound care products.

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	See questions	✓
• 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	See questions	✓
• Identifies alternatives/what would have done differently		✓
Learning goal identified	✓	

Reviewed by: Patricia A. Slachta Date: 7/24/25

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