Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ___Anna Saylor, RN_____ Day/Date: _8/21/25_____

Number of Clinical Hours Today: __8__ Number of patients seen__**4**__

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

Preceptor: __Adam Shaw_____

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, and any additional activities.

Today I was with the inpatient stoma team. We saw only four patients. Two of them had wound vac changes. One was a sacral wound and the other was a chest wound around a drive line site. The patient with the sacral wound around is who I did my journal on. The third patient was a 47 year old male with colon cancer and had a surgery to remove a mass from his colon and it did not heal properly and he ended up with a loop ileostomy (Hartman's procedure). We had seen him first in the morning and he was very angry at his situation and upset that he had not slept through the night. His wife was with him. He declined any teaching and did not want to learn. We did inform the wife of the ostomy class (that the unit nurses teach) that was happening that day and she was very receptive. We walked her to the classroom so she knew where to go and explained that her husband was going through a lot and that she will accept all the teaching we can offer. We set an appointment to go back a 1pm. The fourth patient was a patient that was post-op day four with a loop colostomy with no gas or effluent in their pouch and we intubated their stoma with a foley catheter.

Types pf patients: sacral wound vac change; drive line with wound vac change, loop ileostomy needed lesson patient refused teaching wife was willing to learn, loop colostomy with no effluent in pouch and stoma needed intubated.

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

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The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

Chart note:

Stoma team ~~to~~ in to see ~~72~~ a 72-year-old female for a follow-up visit for routine wound vac dressing change to stage 4 pressure injury to sacrum. Patient was admitted to the hospital on 8/13/25 for UTI. Has a past medical history of non-ischemic CM, CVA, A-fib, PVCs, and ablation. Currently being treated with IV Rocephin for the UTI. Medications reviewed. HGB 9.7, ProBNP 1833 all other labs wnl. Patient is in bed and just medicated for pain in anticipation of a dressing change. Currently states she is having no pain. Daughter is at the bedside. Patient agrees to a dressing change and for her daughter to be in attendance. Patient rolled onto her left side, and the old wound vac dressing was removed with adhesive remover. Moderate~~d~~ amount of sero-sanguineous drainage in vac canister. Wound cleansed with normal saline and patted dry. Wound measures 7.5cm x 10.2cm x 5cm with undermining from 10 o'clock to 5 o'clock, with the deepest measuring 3.5cm. Wound bed is beefy red with granulation tissue. No slough or necrotic tissue noted. Bone is palpable at the proximal wound bed. Periwound skin is pink and intact. Minimal sero-sang better to spell it out drainage present. Wound cleansed with saline and patted dry. Vac drape applied to the periwound and drape applied out to the right hip to create a base for a bridge. Hollihesive was applied to the 6 o'clock edge of the wound due to proximity to the anus. Stoma paste applied over hollihesive. Black foam cut into a spiral shape and placed into the wound and extended onto the right hip for the bridge. Vac drape applied over entire wound. One-inch diameter hole cut into black foam on the right hip bridge. Trac pad applied and wound vac connected. Suction set to 125mmhg and seal achieved. Patient repositioned for comfort on her right side, supported with pillows and a turning wedge. Patient and daughter updated on measurements and overall look of wound. All questions answered. Patient tolerated dressing change well. Patient states she is getting up for short amounts of time with pt/ot and plans on returning to a LTAC center at discharge for continued pt/ot and wound care. States her appetite is getting better and daughter has brought oral supplements for her to drink if she can not eat a meal. Encouraged high-protein foods. She is currently using a glide sheet with pillows and wedges in bed and states that the staff assists her to turn while in bed. Encouraged her to turn side to side while in bed, currently on a LAL mattress. She currently has a Foley catheter and is continent of stool. Using a waffle cushion for the chair when getting out of bed.

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	3
Mobility	2
Nutrition	3
Friction/Shear	2
Total	18

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)

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1. Change wound vac dressing every Monday, Thursday and PRN for your own practice see IFU at end of document regarding VAC changes.
   Remove old dressing.
   Cleanse wound with normal saline and pat dry.
   Apply Vac drape to periwound and left or right hip to create bridge.
   Place hollihesive and stomahesive paste to 6 oclock edge of wound to assist with seal
   Cut black foam into spiral shape and fill in wound leaving piece of foam out to one hip for bridge
   Cover all black foam with vac drape.
   Cut one inch hole in drape at end of bridge and apply trac pad over hole.
   Connect the vac and apply continuous suction at 125 mmHg.
   Change the drainage cannister when full.
2. Continue use of LAL mattress while in hospital
3. Assist patient in turning side to side every two hours and as needed. Consider not having patient lie on her back except at meal time…
4. Continue use of glide sheet, wedges and pillows to offload pressure
5. Place pillows under legs to elevate heels off bed.
6. Nutritional consult
7. Continue PT/OT
8. Ok for patient to be up out of bed in chair for no more than one hour – three times a day for meals.

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

I would have extended the Hollihesive around the periwound. Her periwound did not have any openings but it was pink and she had very frail skin. I also would have used Cavalon skin barrier to her periwound. I totally agree with both of these thoughts & had actually written them above! Otherwise her wound looked very clean and healthy and I would not have done anything else differently. As long as the *beefy* red was not friable…

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 today was to assist with a wound vac change. I was able to accomplish this x2. It has been very helpful to have different preceptors to see how different people approach different situations. good

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
Tomorrow is my last day, and I am with the inpatient stoma team. I do not have any specific skill that comes to mind that I have not seen or done. I find it helpful to work through pouching issues and would like to continue to work on this.

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,	✓	

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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: Patricia A. Slachta___ Date: 8/29/25

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