Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: __Rochelle Schadegg_____ Day/Date: _Sept. 18, 2025 (Day 4)_

Number of Clinical Hours Today: __8__ Number of patients seen__**5**__

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

Preceptor: _Janelle Holtz_____

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, and any additional activities.

Had five patient contacts to day with my preceptor, three patients with high output ileostomies with leaking issues, one post op day one patient for stoma and pouch check and one patient for NPWT dressing change. The first patient with a high output ileostomy had an established stoma but had a leak overnight and required assistance with pouch change. On assessment there was a small ring of denuded skin around stoma which was dusted with stoma powder and protected with skin barrier washer and topped with a convex pouch to help funnel drainage. The second patient with a high output ileostomy also had a ileal conduit which also appeared to be leaking, the patient's pouch change was a bit of a challenge as he was having significant discomfort to the skin d/t irritation for the effluent and this caused the patient to not want to have the area touched. When inquiring with the bedside nurse about medications for pain/discomfort the patient had no PRNs. We were told by bedside staff that the patient is just non-compliant and there wasn't anything they could do, we were persistent and ended up getting PRN medication for pain, once the patient had pain management they were able to tolerate the pouch change. The last patient with a high output ileostomy reported that the pouch was leaking two to three times a day, on assessment of the abdomen the stoma was set within a deep crease and fairly close to the surgical incision that was slightly dehisced and draining and the patient had a lot of loose skin to the abdomen that were all contributing to not getting good adherence of the pouch. To combat these challenges we used a firm convexity with strip paste to fill in the deep creases, stoma paste between the pouch and a hollihesive washer, aquacell over the dehisced area of the surgical wound to absorb drainage, re-enforced with extra tape around the edges and added pouch belt for support. We also recommended having the pouch attached to the gravity bag or more frequent emptying. The patient who was post op day one was due for a pouch check which was intact and did not required changing and the stoma looked healthy.

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

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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.

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

Chart note:

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	2
Mobility	2
Nutrition	2
Friction/Shear	2
Total	14

Follow up assessment and NPWT dressing change for a 72 y/o female admitted for LVAD placement who developed a stage 4 pressure injury to the coccyx while in the ICU. Past medical history includes non-ischemic cardiomyopathy and HF, A-fib, DM2, hypothyroid, CVA, HTN and HLD, concern for cachexia on admission. Past surgical history includes ICD then LVAD placement. Medication list reviewed. Patient was premedicated prior to dressing change for pain. Old dressing was taken down, one piece of foam removed from wound bed and one piece used to bridge to track pad, peri wound skin had hollihesive picture frame which was also removed. Wound bed and peri wound skin was cleansed with normal saline, peri wound patted dry. Wound measures 6 cm long, 6 cm wide and 1 cm deep with 4 cm undermining at 11-12 o'clock. Wound bed is red and moist with granular tissue, there is a dark maroon area noted to the wound bed at 10 o'clock, it does not appear to be necrotic, at 4 o'clock the is an area the no longer has any depth and is flush with skin. Wound edges are flat and peri wound skin is dry and intact, no signs of erythema or induration. The was a scant amount of serosanguinous drainage, no odor noted. After cleansing new foam place to wound bed, two pieces cut to fit the contour of the gluteal cleft, a third piece was used to bridge track pad to left thigh. Cavilon no sting skin barrier used to the peri wound skin with hollihesive frame, at the 4 o'clock area that no longer has depth to pack foam but is still open covered with aquacell then hollihesive. Adhesive dressing placed over foam and hollihesive with new track pad placed. NPWT restarted at -125 mmhg, device should good suction and no leaks. Patient tolerated with moderate distress, checked in with patient frequently she reported that the pain was not significant, but she was feeling particularly anxious, family reports patient has significant anxiety. Made sure to check in with patient frequently and offer frequent breaks. Once procedure complete, repositioned patient to right side and ensure comfort. Follow up/plan of care at this time is possible discharge this weekend but unsure, if still admitted team will follow up for dressing change next week. Patient and family denied any further needs or questions at this time and is agreeable to follow up plan.

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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)

- NPWT dressing change: remove old dressing and ensure all foam is removed. Cleanse wound and peri wound skin with normal saline, pat peri wound skin dry. Use Cavilon no sting skin barrier to peri wound skin. For areas without depth for foam placement but are still open, cover with aquacell and secure with hollihesive skin barrier wedge and picture frame wound. Cut foam to fit contours of wound bed and bridge track pad away from boney prominences. Low continuous suction at -125 mmHG. Change dressing twice weekly, if the device becomes disconnected/no suction for more than 2 hours switch to wet to dry dressing.
- Turning and repositioning every 2 hours using wedge supports to off-load coccyx/sacrum.
- Use glide sheet for repositioning assistance to help prevent friction.
- Nutrition consult, patient is low weight on admission. Concern for inadequate protein intake, may need supplement to meet needs for wound healing. Also want to make sure that blood sugar is stable.
- Emotional support for anxiety, check in with patient frequently throughout procedure, offer breaks, encourage deep breathing.
- Family support: Involve family and address any concerns they may have. Family at bedside is very involved in patient's care and wants to be kept informed.

Describe your thoughts related to the care provided. What would <u>you</u> have done differently

The current wound care appears to be having a positive effect, family reports that undermining has decreased 5 cm since the initiation of the NPWT and the wound has decreased in size. I would want to make sure that the patient has had a nutrition consultation, as there was note in the H&P of concerns for cachexia on this patient and she is low weight. Looking at the notes and orders, I did not see nutrition consulted on this admission and I think this could be contributing. I would also like to consider having a conversation with the provider and patient/family about premedicating for anxiety instead of pain before the dressing change. The current premedication order for pain is a very low dose and the patient's anxiety appears to be distressing than the pain.

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?

See patients with more complex wound care needs and dressing changes.

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What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
Continue to seek out more complex patient care needs/situations.

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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: _____ Date: _____

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