Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: __Lisa Katrowski_____ Day/Date: __9/25/2025_____

Number of Clinical Hours Today: _8___ Number of patients seen_**9**___

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

Preceptor: _Kristine Woodworth_____

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.

Had a total of 9 patients today. Went to see a patient with a suprapubic catheter, talked with the patient, and scheduled a time to change the catheter after supplies were available. Went and rounded on the patient, making wound care recommendations. Check on patients and did rounding for preventive pressure injuries. Worked with the current Wound treatment associated and tested them out on skills. Completed a monofilament test and changed a wound vac today.

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.

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

Chart note: Patient is a 45-year-old male with a past medical history significant for diverticulosis and multiple bowel obstructions with no prior history of abdominal surgeries. He came into the hospital with abdominal pain that was similar to his last bowel obstruction. Patient was found to have abdominal cocoon syndrome now, post-extensive lysis of adhesions with partial skin closure 8/11 with JP and Malecot placement near small bowel stump, currently wound vac in place over open abdomen. Seeing patient for wound VAC dressing change. Went in and introduced myself to the patient and explained I

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was coming in to do a dressing change. Ask the patient if he was having any pain. He stated the only thing bothering him at the time was pain at the JP site. Looked at this area and noted skin had a small amount of erythema on the edge of the incision. Cleaned the area well and applied 3M barrier film and split gauze to this area. Next, I started to gather supplies to do a wound VAC change. Patient said surprisingly that the open area on the abdomen was not bothering him or when the changes were done. After removing the dressing, the area was found to be pink with necrotic tissue covering 50 percent of the wound base. Edges of the wound base are well defined. No fluctuation, induration, or odor noted. The area was cleaned with Vashe, and a nickel-thick layer of Santyl was applied to necrotic tissue. A piece of oil emulsion is placed as a contact layer over the wound. One piece black Granufoam applied to the wound, and suction initiated at -75mmhg with a good seal. Next VAC dressing change is due Saturday by EGS.

Current medication list: diazepam, enoxaparin, ketorolac, lidocaine patch, nystatin topical (groin area), pantoprazole, fentanyl, and collagenase. Labs were within normal range.

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	3
Mobility	4
Nutrition	3
Friction/Shear	3
Total	21

The patient has a Braden risk score of 21. Patient is aware and educated on the importance of moving and shifting weight while in bed to help prevent any pressure injuries. Patient is currently working with physical therapy as well as occupational therapy. Patient had been able to get out of bed with assistance and sit up in the chair in the room.

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)

Remove old dressing.
Clean the wound base area with Vashe.
Apply 3Mbarrier film to the border of the wound base.
Apply a nickel-thick layer of Santyl over necrotic tissue.
Cover the wound base with a contact layer of Oil Emulsion.

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Cut a small Black Granufoam to fit the wound base and place it on the wound.
Cover with transparent film and attach VAC track to the wound.
Attach the tract to wound Vac tubing and set pressure to -75mmHG.
Turn on the machine and make sure the wound VAC is working and pressure is set to the correct amount and has a proper seal.
Wound Vac should not be left without suction for more than two hours, as it increases the risk of infection.
If any issues with wound VAC, please page.

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

The wound Vac change went pretty smoothly. It is always important to make sure that all items that are needed are collected and in the room. When seeing this patient, he had concerns about his JP drain. It was important to address these issues and make sure the skin and area were intact and had proper treatment and dressing applied. The patient seemed relieved to have someone who would listen and take the time to look at it. The patient just needed support and reassurance that the area is doing well and that his concerns were heard and validated.

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?
After looking over the list of patients, I wanted to complete the wound vac on my own, as well as complete the placement of the suprapubic catheter. I was unable to place the catheter today, but I am hopeful about doing that skill soon.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
I want to continue focusing on wound care and dressings for the best practice and dressings for wounds.

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	✓	

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• 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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