Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Sherrie Powell Day/Date: Friday 9/26/2025

Number of Clinical Hours Today: 8 Number of patients seen **4**

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

Preceptor: Denise Santos

Clinical Focus: Wound ____ Ostomy ____ Continence X

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.

My clinical day began with a total of 6 consults in the acute care setting of the hospital. Two of my intended patients were early discharges and left before being seen, leaving one wound VAC, two leg wounds, and an order for a suprapubic catheter exchange. The wound VAC dressing change was on a wound that I applied a wound VAC dressing to last week. This patient had an Integra matrix graft to his wound and required a simple dressing with oil emulsion as a contact layer between the black Granufoam dressing and the Integra matrix graft. One of my patients with leg wounds was treated at the outpatient wound care clinic. This patient's last visit to the wound care clinic was in the earlier part of the week. The consult was for wound care recommendations, so I added recommendations that mirrored what he was sent home with from the wound care clinic. The second wound was a patient with a highly exudating venous stasis ulcer. The wound did not show any signs of infection, and recommendations were Aquacel and ABD pads, wrapped in Kerlix to manage the exudate. My last patient needed a suprapubic catheter exchange. We discussed the process of obtaining an order for the specified catheter size, the balloon size, and the material (silicone vs latex). It was a process getting the correct catheter delivered and coordinating premedication and the patient's willingness to allow WOC to change it; however, the suprapubic catheter was exchanged without any issues.

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:

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	2
Total	19

WOC is consulted to do a suprapubic catheter exchange, per the doctor's order. Patient is a 53-year-old female admitted for multiple falls. Patient's suprapubic catheter is exchanged routinely every 4 weeks, in the outpatient setting. Patient with a past medical history of cystitis, anemia, anxiety, major depression, chronic pain, diabetes with neuropathy, DVT, dysuria, ileostomy, neurogenic bladder, pulmonary embolism, and osteomyelitis. Patient greeted and WOC role explained. The patient agreed to have the catheter exchanged, and the bedside nurse is in the room to premedicate the patient with pain medication as ordered. The old catheter was assessed, and the tubing and balloon size were compared with the order. After creating a sterile field, a 10ml syringe was used to deflate the catheter balloon, and the old 16 Fr 5ml balloon suprapubic catheter was removed. Peristomal skin is clear and intact. After donning sterile gloves, a sterile drape was placed around the insertion site. While maintaining sterility, the insertion site was cleaned with an iodine swab x 3 times, wiping in a circular motion from the insertion site outward. A new 16 Fr 5ml balloon suprapubic catheter was inserted with a small amount of yellow-colored urine return. The catheter balloon was inflated with 10 mL of normal saline. The catheter was secured to the leg using a securement device. The patient's abdomen was cleaned with normal saline. Next suprapubic catheter exchange is due on 10/26/25.

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)

*Wash your hands thoroughly before and after handling the catheter or drainage bag

*Assess the insertion site for any redness or bleeding

*Clean the insertion site with normal saline or mild soap & water

*Clean the catheter tubing daily by gently wiping the external portion of the tubing with a clean cloth and warm water or mild soap, starting at the insertion site and moving away from the body.

*Inspect the catheter tubing regularly for kinking

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*Measure urine output every shift and note the color, clarity, and odor of urine

*Use a leg strap or securement device to secure the catheter to prevent pulling at the insertion site

*Avoid opening the system unnecessarily to reduce the risk of infection.

*Keep the drainage bag below the patient's bladder and off the floor

*Notify the provider if no urine output for 4-6 hours, if there is leaking around the catheter, or if the urine becomes cloudy or foul-smelling

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

I feel that the care provided was effective and would not have done anything different. I did not have many patients today; however, I was very satisfied with being able to exchange the suprapubic catheter. I do not have a chance to see many of these types of consults due to the units I cover. I always saw it as a complicated task, but it went well.

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 complete the suprapubic catheter exchange. My goal was met.

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

I will have to wait until our consult list is printed. I am hoping to get a stoma marking or an urostomy patient.

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For instructor use only. Do <u>not</u> 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	✓	

Reviewed by: _____ Date: _____

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