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: __Monday 10/6/2025____

Number of Clinical Hours Today: _8___ Number of patients seen_**5**___

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

Preceptor: ___Denise Santos_____

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.

I saw 5 patients today in the acute care hospital setting. I had two wound VACs, an ostomy teaching for a patient with an new ileostomy, a right lower extremity vascular wound, and a sacral decubitus ulcer to evaluate and give wound care recommendations. My first wound VAC was in the groin and required simple dressing, but the assessment of the wound was extensive; my second wound VAC was interrupted because the patient had to go to dialysis emergently. We dressed the wound in a moist saline dressing with a plan to do the wound VAC dressing when the patient returned from hemodialysis, unfortunately, the patient passed away. My ostomy teaching involved the patient and his spouse. My sacral ulcers after evaluation required Santyl daily; however, I did consult surgery for a debridement of the necrotic eschar. My last patient of the day had wet wounds to his bilateral lower extremities, being worked up for venous insufficiency, and requiring daily dressing with Aquacel Ag, ABD pad, Kerlix, and tape.

Types of patient: new ileostomy teaching, unstageable pressure injury, venous wounds, NPWT.

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.

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Chart note:

Braden Risk Assessment Tool

Sensory Perception	2	Q4 & PRN pressure injury inspection
Moisture	3	Clean and protect with barrier paste, external urinary collection device
Activity	1	Suspend heels with heels up
Mobility	2	Q2 turns; limit time on back
Nutrition	3	Minimized disruption of tube feeds; Nutrition consult
Friction/Shear	2	Maintain sling under patient to move and reposition
Total	13	

WOC seeing 68-year-old female for NPWT dressing change to right groin. Patient admitted for fall on 9/2 with surgical intervention for open treatment of left femoral shaft and supracondylar femur fracture and repair of right femoral fracture with incisional dehiscence. Patient with past medical history of hypertension, malignant breast tumor, pulmonary embolism, fat embolism, and osteoarthritis. The patient was greeted in bed with spouse at bedside. WOC role explained, and patient and spouse agreed to evaluation and wound VAC change. Old dressing removed and right groin evaluated to reveal full thickness wound with adjacent surgical incision approximated with staples at 6-7 o'clock. Wound cleansed and measured at 3.8cm x 3.5cm x 7cm. Wound is red, pink, with scattered adipose tissue visualized in the wound bed; copious amount of thin yellow effluent; no odor noted. Wound edges poorly defined; periwound macerated and erythematous with large area of induration, involving the adjacent surgical incision. Large amount of yellow-greenish purulent drainage expressed from different point of entry at 6-7 o'clock relative to the primary wound at the beginning of the surgical incision. Depth measures 6cm under the surgical incision. Wound irrigated with normal saline and wound cultures obtained from the primary wound and the wound under the incision line, inserting a separate swab to the full depth of each wound. Wound then irrigated with Vashe. 3M no-sting barrier film applied to periwound before draping around the primary wound. 1- piece black Granufoam filled into the wound with suction at -125mmHg. Sutured surgical incision covered with Aquacel Ag, 4x4 gauze, and secured with Tegaderm. Patient tolerated dressing change and required no pain medication. WOC will continue to follow this patient. Surgical resident paged to make aware of induration under surgical incision and asked to further evaluate for possible abscess formation. Bedside RN made aware of the plan of care.

If device leaking or dressing integrity compromised, unit RN should assess dressing and device prior to paging WOC. If therapy remains off for greater than 2 hours, a rescue dressing of saline-moistened gauze should be applied. Please reference WOC website on portal page for troubleshooting NPWT. If any new deterioration noted prior to WOC follow up, please alert the attending service and contact WOC via Vocera pager Mon-Fri, Day shift. To reach the WOC RN, please search WOC in Vocera and select the appropriate distribution list. For any new WOC related issues that develop, please place a new WOC consult.

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.

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WOC Plan of Care (include specific products)

*Wash hands thoroughly with soap and water before any wound care.
*Monitor the system for proper suction, which should cause the dressing to collapse.
*Regularly check that the tubing is not kinked or compressed, and that the canister is secure.
*Change the canister as instructed, usually when two-thirds full or at least weekly.
*Monitor and assess the wound for increased redness, odor, or drainage, and contact the provider if you suspect an infection.
*Ensure adequate nutrition to support wound healing.
*Contact WOC if the dressing is not holding suction, the wound vac is malfunctioning, or you are unable to find a leak or fix a persistent problem with the seal.
*Remove VAC dressing and place normal saline moist dressing, if therapy has been off for more than two hours while the system was not working properly.

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

The care I provided was not outside of what is standard at my facility. There is nothing I would have done differently. I was a little flustered because my patient passed away. His VAC dressing was in his chest, and it was painful to remove. It bothered me a little that I caused him pain as such a critical time but how could one suspect his outcome.

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 attempt to get a continence patient but I did not have any, unfortunately. I was thinking that my patient with the sacral ulcers might have stemmed from incontinence but is ulcers were directly related to sitting in a wheelchair all day.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
I again will try to see more continence patients. I do not have many of them that I have seen this clinical session.

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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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