



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

### Daily Journal Entry with Chart Note & Plan of Care

Student Name: KaTrina Weston Day/Date: 10/20/25

Number of Clinical Hours Today: 8 Number of patients seen 9

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Jennifer Mullins, RN, CWCN

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.**

We saw 8 patients today, all were wound focused. While most were Pressure Injuries, we also saw Venous Leg Ulcers, Skin Tears, a Diabetic Foot Ulcer, and a Surgical Wound. We were also able to observe a fistula that is being covered by a wound management system. Since the system was installed yesterday and was completely intact, we did not remove it. We were able to visualize the two bowel sections. This was something different for me and something that I am glad I was able to see it. We saw a gentleman with bilateral feet wounds that were suspicious for osteomyelitis. X-rays had already been ordered by attending. By the end of the day the x-rays were back, and both showed suspicious for acute osteomyelitis and referral for Infectious Disease was sent for consult. I was also able to go with Nicki Blasiolo, APRN-CNP, CWO CN and Kylie (the other Cleveland Clinic student) for colostomy and wound assessment with NPWT. It was interesting to see that the previous orders from clinic in Chicago (pt in town visiting). The orders included using Hydrofera Blue under a NPWT device. Talking to Nicki and Kylie, it seems like maybe they were using it for antimicrobial properties.

Types of patients: Pressure Injury, Venous Leg Ulcer, Skin Tear, Diabetic Foot Ulcer, and Surgical Wound.

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:**

This is a 91 year old female being seen today for Stage 4 Pressure Injury to coccyx. She has a PMHx of HTN and HLD. Previous Surgical History includes Cesarean section (1952 and 1959), Left Foot OP Surgery I&D (3/20/24), Left Cataract Removal (2019), Bilateral Carpal Tunnel Surgery (2019), Tonsillectomy & Adenoidectomy (<12 Y/O), Partial ABD Hysterectomy and Bladder Repair (Date Unknown), and Total Hip Replacement Bilateral (January and June 2025). Medications reviewed. She lives in a SNF at this time and was sent to ER on 10/11/25 related to nausea/vomiting and shortness of breath. The Pressure Injury is the only opening she has upon admission. Physical Exam was completed and there was no other skin breakdown noted. She has a urinary catheter but is incontinent of bowel. Pedal Pulses palpable bilaterally. She currently denies shortness of breath and nausea/vomiting. Coccyx wound measures 3.5x3.5x2.7 with undermining from 11-2 that is 3 cm at its deepest. There was small serosanguineous drainage noted. No odor. Wound bed has red granulation tissue along with yellow/brown slough. There is bone palpable but not visible in wound bed. Peri-wound is macerated but otherwise intact. Previous order was for Pack with hypochlorous acid (VASHE) soaked gauze then cover with silicone border foam or ABD and tape. Change BID/PRN if soiled or non-adherent. There was no change to current orders. She has pressure injury prevention orders: Turn and reposition every 2 hours, offload heels with boots or pillows, and utilize low air loss mattress. Barriers to Healing: Age, Body habitus, Comorbid conditions, and Mobility. Wound team will plan on following up in 1 week.

**Braden Risk Assessment Tool**

<i>Sensory Perception</i>	4
<i>Moisture</i>	3
<i>Activity</i>	2
<i>Mobility</i>	2
<i>Nutrition</i>	3
<i>Friction/Shear</i>	1
<i>Total</i>	15

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)**

1. Wash wound with wound cleanser or normal saline. Pat dry. Gently pack with hypochlorous acid (VASHE) soaked gauze then cover with silicone border foam or ABD and tape. Change BID/PRN if soiled or non-adherent.
2. Order then utilize heel suspension boots to prevent breakdown. Ok to use pillows for offloading until boots are in room.
3. Turn and reposition patient every 2 hours.
4. Make sure low air loss mattress is set appropriately per weight.

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## 5. Call for changes in wound, wound dressing concerns

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

After talking with Jennifer about the use of wet to dry dressing and understanding that with admitting provider, wound care, floor nurses, and anyone else that wants/needs to assess the wound it is not possible/appropriate to use a more expensive dressing with longer frequency between dressing changes. If we were in a different setting or patient was able to tolerate then hydrofera blue or even better NPWT would be appropriate for this wound.

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?**

To learn about Inpatient Wound Care and see what a normal day looks like for a Certified Wound Care Nurse.

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

Continue to learn about different dressing types that are appropriate in the Inpatient setting since that is not the area I am familiar with.

**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, 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:		

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• 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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