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: __10/23/2025_____

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

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

Preceptor: __Erica Aiken_____

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.

Two patients were ostomy patients one had a leaking pouch and the other patient needed/wanted to go over ostomy care and treatment before they were discharged today. One patient had come in with a stage 3 pressure injury they had been at the facility for 3 weeks doctor wanted WOC to reassess area and make new recommendations before patient was discharged. Patient has chronic venous stasis ulcerated lower extremity wounds that needed to be seen and dressing orders placed. Last patient has a suspected pressure injury placed and wanted recommendation went to see patient area was not a pressure injury just hyperpigmentation and moisture associated skin damage.

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 75-year-old male with past medical history of opiod use disorder an Suboxone, A-Fib, HTN, HLD, history of avascular necrosis of right hip, chronic venous stasis ulcerated lower extremity wounds. Patient presented to the hospital for a recent fall, symptoms of opioid withdrawal, and pain in

his lower extremity wounds. Is currently being admitted for withdrawal symptoms. Went to the patient and introduced myself, explaining that I was here to assess his current wounds. I then started the conversation by asking how he felt his legs were doing. The patient states that he does not feel his legs have worsened since the last visit. He lives with his son, and his son changes his wounds every 3 days. They are cleaning the area with Vashe cleanser, applying abd pads, and kerlix. He denies any fever, chills, or warmth in the lower extremities, just generalized pain in the leg areas. Pain is a chronic issue for the patient providers, and addiction medicine is working together towards developing a better plan to help control his pain while keeping in mind his current drug use and history. BLE noted with venous stasis and erythema, right greater than left. Thick scale and scabs were noted on the bilateral lower legs. On the right leg, a 4 x 5 open area with full-thickness tissue loss. Both legs need to be cleaned and dried, and lotion applied to dry areas. Cleanse wound with Vashe solution. Cut to fit Aquacel AG sheet cut to fit open wound to right leg, cover with abd pad and wrap with Kerlix every day. The patient should have compression bandages applied to help reduce swelling and help with the blood flow. Patient had been referred to the wound clinic multiple times but has not follow up once he is home. Strongly recommended the patient to follow up with them when he leaves to help hopefully improve the legs and heal the wound. I was able to add a new consultation to the wound care center for this patient.

Braden Risk Assessment Tool

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

Patient is at risk for friction and shear problems. Patient can walk with a walker but has been more limited due to pain in the legs. While the patient is in bed, turn and reposition the patient every 2 hours. Use lift or transfer devices if the patient is not moving on his own. Encourage increased activity and good nutrition intake.

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. Clean wound with Vashe and the surrounding areas of both legs. Dry legs well, apply lotion to the scales on the legs, avoiding open wound area.
2. Cut to fit Aquacel AG to the current wound dimension.
3. Apply an ADB pad and wrap in Kerlix.
4. Apply a compression bandage to both legs.

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5. Encourage increased activity and nutritional intake.
6. Turn and reposition patient Q2 hours.
7. Make sure to elevate legs and suspend heels.
8. Inspect skin at least every 8 hours.

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

The patient comes to the hospital very frequently for opioid withdrawal. Tried to talk with the patient about his situation, but he can not see anything wrong with what he is doing and is not ready to conquer his addiction at this time. Patient states he is doing well and that his son is helping him, and they are doing okay. I tried to explain to him how it would be so beneficial to actually go to the Wound Care Clinic after he leaves the hospital this time. He was agreeable, but I do not think he will follow through with this because he says he will, but has not yet done it. I wish I could help him understand and see how it will really make his legs feel better. I feel addiction issues are taking most of his energy, so the wound care regimen is not high on his radar. He is currently talking and working with addiction medicine, so I hope he will find a good plan soon.

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?
I was able to see both wound care and continence patients today.

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

I would like to do another ostomy teaching.

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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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