Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Elizabeth Lyons Day/Date: 10.28.25

Number of Clinical Hours Today: 8 Number of patients seen **6**

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

Preceptor: Brittany Gesing

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.

64 yo woman with leaking loop ileostomy with red rubber catheter as stoma rod (I do need help with pouching around rods, and was so happy to get to see this patient with Brittany). Pt with wound vac dressing change-please see note. 52 yo male left lateral LE wound vac dressing change. 54yo male with diverticulitis, resection with anastomotic leak, and POD 1 end colostomy. First day education with pouch change-used one piece coloplast soft convex with ring due to indentions at 3 and 9:00 and semi soft abdomen. 52yo woman with Crohn's with loop ileostomy and j-pouch POD 1 (Brittany related this was quite rare, usually 3 stage approach and this was the 2 surgeries at the same time. Pouch change and taught patient and husband. 2 piece convex with ring.

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:

Braden Risk Assessment Tool

Sensory Perception	3

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Moisture	3
Activity	2
Mobility	2
Nutrition	4
Friction/Shear	2
Total	16

58 yo male with hx of HF and EF of 20% and ICD. T2DM, HTN, PAD, RBKA, CKD stg 3, stroke, use of smokeless tobacco, Afib.
Pt admitted with left foot gangrene. Left foot with dry gangrene and recent hx of bacteremia with 2 weeks of IV antibiotics at outside hospital.
TEE revealed mobile echodensities necessitating CRT-D extraction from left chest and new CRT-D implantation on R chest. Pt will require IV antibiotics until 11/6.
S/P left ankle disarticulation on 10/3. NPWT dressings Q Tuesday and Friday. Plan for outpatient f/u regarding LBKA surgery on 11/13 after IV antibiotic course complete.
WOC team assessed left leg wound and changed NPWT dressing. Pt tolerated well, denied pain, but stated more than twice that he wished he could "just die" and expressed frustration regarding the staged approach to LBKA, does not want to go to SNF to wait for next surgery. Active listening utilized, pt expressed frustration and disbelief when staff broached topic of serious infection requiring resolution with full course of IV antibiotics and need for cardiac stability prior to extensive amputation surgery.

LLE wound bed with exposed base of tibia, yellow, red, moist tissue with yellow and brown slough scattered throughout wound bed. Wound edges are flat. Periwound with skin intact and without discoloration.
Moderate amount of serosanguinous drainage in cannister. No odor noted to wound.
Measurements: 12.cm x 13cm x 3.5cm. No undermining or tunneling noted.
Periwound skin cleansed with soap and water and patted dry. Skin prep applied and allowed to dry.
Periwound draped with transparent film.
One piece of Urgotul AG contact layer applied to wound bed over exposed bone.
Four pieces of black foam used to wound bed and bridge. Transparent drape utilized and trac pad applied.
Suction set to -125mmHg. Foam compressed easily, no leaks noted.

Discussed patient statements regarding desire to die to nurse and MD who were outside of room. Pt had expressed this to nurse as well. Psychiatry Consult was placed.
PT/OT, Dietician, Case Management are following patient.
Discussed possibility of Diabetes Educator consult with doctor when patient receptive to teaching.

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)

WOC Team will change NPWT dressing QTF until discharge.
Continue NWB LLE
Offload bony prominences, turn patient Q2 hours.
Add LAL pump to bed to improve microclimate of skin.
Tobacco cessation education.

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

Would request Juven for healing if it were available.
Would spend time with patient discussing his frustration and attempt to relate to him and educate regarding care, diabetes, activity, PI prevention, etc, if he became receptive -that would be in a perfect world where we'd have hours to spend with patients…

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?

Wound care. Met!

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

Parastomal skin irritation treatment.

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	✓	

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• 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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