Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

10/23/25
Student Name: ___Elizabeth Lyons_____ Day/Date: __10/23/25
_____

Number of Clinical Hours Today: ___8__ Number of patients seen__**6**__

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

Preceptor: __Erica Yates_____

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.

Saw a pt with IV extravasation that was purple and 2 spots of soft brown eschar. Medication that caused it is unknown-it occurred in OR and was not found until after surgery. This was the second visit a few days later, and area was treated with small amount of hydrogel and urgotul, secured with kerlix. 64yo male POA DTPI now unstageable: continued stooling liquid stool during assessment, pt confused, in restraints. Slough over wound, Erica spoke with provider about possibility of FMS (had initiated TF), has LAL bed, desitin ordered. 81yo male scalp wound-chronic from biopsy site, recommend bacitracin, several small wounds on toes, pt sees podiatrist who prescribes ointment-pt cannot recall the name. R great toe with chronic wound that opens “every now and then” is now draining. Cleansed and applied aquacel. 86yo with stage 4 to sacrum: see Chart Note. 66yo male paraplegic with new DTPI to sacrum and scrotum open area-Urgotul and allevyn. Urogotul and ABD pad and elevate scrotum (very edematous). Wife asked Erica to check abdominal incision which is being managed by surgery, it had not been changed b/c sx thought nursing was doing them and nursing thought surgery was. Erica changed dressing and talked to sx PA and placed orders. 67 yo woman with worsening sacral wound. Pt in ICU, intubated, tube feeding. Unstageable wound had spread across gluteals. Placed urgotul to areas and covered with ABD pad and anchored with silicone tape. Repositioned patient with Z-Flow positioner pillow.
For all patients-measured wounds, took photos, described, and learned about rationale for treatments chosen.

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,

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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	1
Moisture	2
Activity	2
Mobility	2
Nutrition	2
Friction/Shear	1
Total	10

86yo female with hx of intracranial aneurysm, HTN, obesity, stroke, afib, DVT. Currently, pt opens eyes when awakened but does not respond to questions. Pt lives in a nursing home and family is not present at bedside to discuss wound and treatment. WCCT is following pt for her stage IV pressure injury to sacrum. The full thickness wound has enlarged and has extended across R buttock. Wound bed is indurated and has tan and brown slough, some of which can be lifted from wound bed in threads. Small amount of red tissue noted to wound bed. Considering depth and nearness of palpated bone, PI is staged as stage IV. Moderate amount of tan, malodorous drainage noted. Periwound is intact, hyperpigmented.

Wound Measurement: 12.5cm x 17.5cm x 2cm. Undermining circumferentially with deepest area 3cm at 8:00

Wound was cleansed with vashe using 4x4, applied to wound and let set for 5 minutes. Patted dry. Thin layer of hydrogel applied to wound bed. Lightly packed wound bed with NS moistened kerlix. Urgotul applied to area of right buttock. Entire wound was covered with ABD pad and secured with silicone tape. Treated periwound with ConvaTec skin barrier wand and allowed to dry.

Pt has low air loss bed with pressure redistribution. Ordered Dolphin immersion specialty bed.

Nutrition is following patient and she is receiving enteral feeding through keofeed which is bridled in nares. She is also eating a pureed diet.

Spoke with hospitalist regarding consulting Plastics for bedside debridement of wound.
Case management is following for discharge needs. Will follow along to confirm availability of recommend wound care supplies at facility.

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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)

Change sacral dressing Q12 hours and prn for soiling.. Cleanse with vashe soak using 4x4 and place in wound for 5 minutes.
Pat dry. Apply thin layer of hydrogel over wound bed. Loosely pack open depth of wound with NS moistened Kerlix (squeeze out excess NS and fluff kerlix to lightly fill wound bed). Apply Urgotul mesh to open area on right gluteal. Apply ConvaTec barrier wand to periwound and allow to dry. Apply 2 ABD pads to cover entire wound and secure with silicone tape.

Turn patient to right and left sides Q2 hours. Pt may be on back when eating meals only.
Offload heels in heel boots at all times.
Consult PT/OT.
Continue Purewick urinary device, cleanse perineum and change device QS and after every bowel incontinence.

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

I learned a lot again today-I know I keep writing that. I'm glad it's true!
We do address wounds in my job much more often than ostomies, and Erica is an amazing preceptor, I regret that I only have 3 days with Erica-but I know I should be grateful for those 3 days!

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?

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See and treat stage 3 or 4-Met! 😊
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) See a type of wound I've not seen before…

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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