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: _Friday November 7, 2025___

Number of Clinical Hours Today: _8_ Number of patients seen__**5**__

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

Preceptor: __Erical 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.**

Today we had 5 WOC consultations for evaluation and treatment recommendations for patients in the acute care setting of the hospital. My first patient had a sacral ulcer that needed Medihoney for debridement of a small area of necrotic slough and border foam dressing. My next patient had a venous ulcer in the setting of lymphedema. We then saw a patient with a small wound on the plantar surface of his TMA. The wound bed was clean, so we opted for normal saline cleanse and Promogran Prisma and adhesive foam. Next was a patient who had a diabetic ulcer in which Podiatry was consulted for. We deferred to podiatry because they were following the patient in the outpatient setting. My last patient was another sacral wound which only needed cleansing with normal saline and Mepilex border foam dressing. Since it was my last day, we did some reinforcement on using the TIMERS method to pick dressing options for specific wounds and then spent the rest of the day doing photo validations.

Types of patients: venous ulcer, diabetic ulcer, lymphedema, sacral ulcer, 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:**

**Braden Risk Assessment Tool**

| | |
|---|---|
| Sensory Perception | 4 |
| Moisture | 4 |
| Activity | 3 |
| Mobility | 3 |
| Nutrition | 3 |
| Friction/Shear | 3 |
| Total | 20 |

58-year-old female being seen and examined at the bedside for “right shin wound”. The patient admitted for fluid overload. The patient has a past medical history of lymphedema, venous insufficiency, venous stasis ulcer, morbid obesity, atrial fibrillation, chronic kidney disease (stage III), dyspnea, peripheral edema, cardiomyopathy, TIA, irritable bowel syndrome (IBS) and essential hypertension.

Greeted patient while sitting in chair and explained the WOC nurse role. Patient agreed to evaluation and ambulated back to the bed without difficulty. No history of ABI evaluation listed in chart. Patient admits “recurrent bouts of lymphedema” and to having pain in the right leg when “legs are down for too long”. Dressing removed to reveal a round full thickness wound the right lower lateral shin area. Old dressing saturated with thick yellow drainage. When interviewed about the previous dressing, the patient admits to not letting unit staff change her dressing since her admission 2 days ago. Patient states she wanted WOC to assess the wound first. Wound has red and yellow tissue with a small amount of yellow biofilm visualized on the surface of the wound. Small amount of serous drainage; mild odor noted. Wound edges well defined; periwound erythematous and macerated with no fluctuance or induration.

Wound cleaned with Vashe to remove biofilm. At this time patient requested medication for pain. Bedside RN at the bedside with pain medication, then the patient allowed WOC to continue. Wound covered with Aquacel Ag, cut to fit the base of the wound, then covered with Mepilex border foam. These dressings are to be completed every other day by the unit RN. The patient tolerated dressing changes after being medicated for pain. The patient refused a referral to outpatient wound care clinic stating she sees a wound care doctor in Pennsylvania.

The patient was made aware of plan of care and agrees. Wound care recommendations communicated to bedside RN. WOC nurse signing off. If any new deterioration is noted, please alert the attending service and reconsult WOC nurse.

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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)**

*Wash hands before and after patient care
*Remove old dressing, noting type, color, consistency, and amount of exudate
*Clean wound with Vashe antimicrobial solution to remove biofilm
*Assess wound bed, wound edges, and periwound
*Measure length, width, and depth of wound Q7 days, while the patient is in the hospital
*Apply Aquacel Ag sheet (cut to fit) to wound
*Cover with Mepilex border foam dressing
*Change dressing every other day and as needed for increase drainage
*Check bony prominences for pressure injury Q4 hours
*Keep legs elevated
*Limit sitting interval to no more than 2 hours
*Notify WOC for any noted increase in exudate, change in wound color, or deterioration of the wound

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

I am satisfied with the care I provided today. I was thinking we would have a more remarkable wound to assess. It was an easygoing day.

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 finish my clinical with my last wound journal. My goal was met.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**
Not applicable

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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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