Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: _Taylor Campbell_____ Day/Date: _11/4/25_____

Number of Clinical Hours Today: __9__ Number of patients seen__**7**__

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

Preceptor: _____Katherine Cesario_____

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's clinical rotation included new admission consults, pressure injuries, and moisture associated dermatitis. Reviewed the list of patients and signed including diagnosis and medications. In addition, reviewing the chart for prior hospital stays and any wounds or pressure injuries on last admission.

One of the cases seen was a 71 y/o African American male, AAOx4, room air, ambulates X1 assist. Hx of CAD, HTN, HLD, CVA, urinary retention and chronic urinary catheter (Foley) in place, and left TMA. Patient came to hospital because of abdominal pains. At the of encounter paint denied pain. Explained to the patient that the primary nurse had requested we examine his skin. He was receptive and a full skin assessment was completed. There was moisture associated skin dermatitis on the buttocks. The treatment plan was explained to the patient, and he consented. The area was pink, moist, fragile. The area was cleansed with hypochlorous acid wound solution (Vashe), pat dried, and Coloplast Critic-Aide Clear moisture barrier cream was applied to the buttocks and covered with foam dressing (Mepilex) the Mepilex is often not necessary for a moisture issue esp. if patient on a breathable pad. This will be applied daily and PRN as needed. Additionally, the use of pH balanced cleaner, yes! Gentle Rain was recommended ongoing for peri care. A foam dressing (Mepilex) was applied to the sacrum to reduce the risk of pressure injury.good idea Offloading, turn and reposition instructions were included in notes and communication out of bed with assistance for ambulation. The medical resident and primary care nurse was updated with the plan.

Another patient encounter was a Caucasian 91 y/o male, AAOX1 to self, room air, maximum assist (activity, ADLs) with a past medical history of HTN, HLD, T2DM, CVA, and glaucoma. Patient was brought to the hospital for fall and altered mental status. Wound care consult was placed by the primary nurse to assess a deep tissue injury to the sacrum. Introduce the plan of action to the patient but considering his mental status he never had questions. A full skin assessment was completed, and a DTPI was confirmed ~~in~~ on the sacro-coccygeal area. The base is maroon with attached edges, round in shape with a wound surface area of 15.71 cm^2. The area was cleaned with pH balance cleanser and dried. Foam dressing (Mepilex) was applied to

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protect the skin from further breakdown. Continue to offload areas with pillows and turn and reposition left-right, right-left, no back positioning to protect the skin from breakdown. The patient's albumin is 2.8 which is low and additional health factors that can delay wound healing includes diabetes mellitus. Therefore, taking the necessary steps to prevent breakdown is very important. The treatment plan was communicated with the primary nurse and the resident doctor. Ok including the pt you wrote this note on you saw 4 additional patients….

NPIAP has started to use deep tissue pressure injury vs. deep tissue injury

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
Moisture	3
Activity	1
Mobility	2
Nutrition	1
Friction/Shear	1
Total	11

EM is an 85 y/o African American female, AAOX1, DNR DNI, on 4L oxygen nasal cannula, was admitted for respiratory distress, AMS, Sepsis. Patient has medical history of Afib, HTN, HLD, CKD4, DM, GI bleed, pacemaker. Patient is incontinent ~~times two~~of urine & stool. 167.6 cm height and 63.8 kg weight. Current labs: albumin 2.4, WBC 15.1, protein 6.1. Current medications: Linezoid 600mg, Vancomycin 750 mg, Meropenem 1g, hydrocortisone injection 50 mg Q6H, Vasopressin 40 units, and Dobutamine 500 mg.

Daughter, health proxy speaks and understand English **1. why is this important? (Communication is key. As a nurse it is important for patients and family to understand what is being explained and how the plan of care will be carried out. It is vital to get patient's input and in this case the healthcare proxy. Ensuring that the healthcare proxy speaks and understands English is vital to patient care. It ensures no ambiguity, reduces risk of disparity, and that transparency is adhered to. I like talking with my patients and plan the care with them. I encourage feedback and for them to ask questions. For those who do not speak English, I utilize the interpreter services.) ,** is at bedside, flew in from California. A wound care consult was placed by the primary nurse to assess sacral wound. The plan of action was explained to the daughter who was very

receptive and agreed. Explained the patient's skin will be assessed and treatment plan will be implemented. The patient was currently undergoing dialysis treatment during our visit. A full skin assessment was completed and unstageable wound on the sacrum was confirmed. DTPI on bilateral heels. The elbows were hyperpigmented. Bilateral lower extremities non-pitting edema.

The unstageable wound base is bleeding, dark purple, red, subcutaneous tissue, painful. Attached edges and irregular border. Peri-wound area is fragile, hyperpigmented, with spots of hypopigmentation, excoriation. Small amount of serosanguineous exudate was observed. Wound has a butterfly shape measuring 8 cm length, 5 cm in width, and depth 0.3 cm. Throughout the assessment explanation was given to the daughter. Good

The treatment plan included dressing to the wound and preventative measures to prevent further break down. The sacral wound area was cleaned with hypochlorous acid wound solution (Vashe), pat dried and Zinc-oxide based Hydrophilic paste (Triad) applied to the peri wound area. Medicinal Honey Impregnated Alginate was applied and covered with foam dressing (Mepilex). Mepilex dressing was applied to the heels and offloaded. How off loaded? Be specific in your note. **(Patient was turned on her left side and offloading wedges were placed behind her back to offload the pressure on her sacrum. Turning schedule is right to left and left to right with no resting on the back Q2H.)**

Wound healing can be delayed due to the health condition for example diabetes mellitus. Additionally, patient is in medications such as vasopressin which can impair blood flow thus reducing blood flow to the tissues. These were explained to the daughter, and the primary nurse was updated. The medical resident was notified in secure communication. Would you put this is the medical record? **(Yes, I would include this in the medical record because it emphasizes patient assessment regarding risk for delayed wound healing and education to the daughter about the treatments. Also, notification to primary nurse and medical team ensures continuity of care.)**

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)

- Cleanse area with Vashe cleanser, pat dry.
- Apply thin layer of Triad to peri wound area. **2. When you use this how do you get the Mepilex to adhere over the ointment? (The goal is to apply small amounts but. Not to spread outside the perimeters of the Mepilex. Wound measurements are 8 cm X 5 cm X 0.3. The measurement for the Mepilex: 6.3 X 7.9 inches is large enough to cover the wound without the ointment interfering with adhesion to the skin.)**
- Apply Medihoney to the wound base
- Apply skin-prep and apply foam dressing (Mepilex) **3. do you have a source from Molnlycke that says you can use skin prep w mepilex? (I do not have any source from Molnlycke that says Skin Prep can be used with Mepilex. They are competitor brand (Smith and Nephew) and Molnlycke Mepilix product was designed with similar technology included SafeTac which is gentle on the skin. However, I do not see any studies contraindication of Skin Prep prior to applying Mepilex. I think it is useful especially if the patient's skin is fragile. I have experienced removing Mepilex from patient's skin with residue on the adhesive. A second skin, using Skin Prep is beneficial)**
- Change dressing daily or PRN if soiled just FYI, this is ok in hosp but a daily foam change is

expensive & they are designed to remain in place for 3-5 days (**Yes indeed. This was a discussion I had with the daughter of a patient recently. Patient has stage 4 sacral wound and we were talking about the dressing change frequency in the hospital versus at home when the wound care nurse comes every 3 days. It also was educational for me to attend the Skin Fair at my job with vendors from different companies, and the presenter talked about the dressing change if exudates touch 3 out of the 4 corners. Finally, it bothers me when I enter a patient's room and there are multiple Mepilex pads in the room which gets trashed when the patient dies or discharged and didn't take them home.)**

- Continue to turn and offload affected area Q2H. Turn left-right, right-left, no back position.
- Apply barrier cream to perineum to prevent skin breakdown **4. which cream? (Moisture Barrier cream (Coloplast Critic-Aide Clear))**
- Continue pressure injury protocol to prevent HAPI.
- Remove sequential compression device (SCD) and examine skin for breakdown. Q shift? Daily? **(Q shift so that intervention can be implemented early.)**
- Apply fluidized boots to protect the heels. Remove fluidized boots daily and inspect feet, clean feet, and moisturize, then re-apply fluidized boots.

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

The patient encounter was a great opportunity to have the daughter involved in the plan of care. Plan of care was explained, and the daughter understood the goal of reducing the skin breakdown. Applying the Medihoney will help to debride the wound. If Medihoney was not available due to the current backorder at the hospital, I would suggest collaborating with medical team and ask the resident doctor to order collagenase ointment to be applied to the wound which debrides the wound. Yes good plan Foam dressing will be applied to protect the wound. Taylor, this is not the purpose of a foam dressing, especially Mepilex which does have several RCTs regarding its efficacy w pressure & shear redistribution **(Thanks for sharing your knowledge. I do see where Mepilex has been effective in preventing pressure injuries.)** Wound healing is challenging because of the health history therefore reinforcing turn schedule and offloading, turn and repositioning to help present worsening skin condition. **5. Ok, what about the low Braden scores that are highlighted? Was she ambulatory at home or bedridden? If ambulatory then ? If not, could she be? (The low Braden scores are indicative of risks that can delay wound healing. Patient's Braden score is 11 scoring low in the categories of Activity, Mobility, and Nutrition, 1, 2, and 1 respectively. The patient is bedridden and limited activities and weakness in upper and lower extremities. Therefore, no active range of motion. ADLs are completed by caregiver at home and staff while in the hospital. Nutritional intake is poor due to lack of appetite and chronic illness. Patient has cognitive decline prior to hospital admission, AOX1. At home Braden score baseline would be similar to the hospital.)**

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?

Monofilament testing and compression dressing with unna boot. The timing for patient visit sometimes coincided with other patient interventions. The monofilament test was not completed because the ideal patient was not available. One of the wound care nurses allowed me to do a compression wrap on her leg. Oh great! It

was interesting and served to help with my experience since the chances of seeing a patient with that needs this type of dressing is low.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
My learning goal for tomorrow is to follow-up on the patients. Attend the Skins Fair and meet the vendors. How exciting!

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	*More specificity*	✓
• 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: Patricia A. Slachta Date: 11/17/25

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