Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ___Terryann Simpson_____ Day/Date: _11/24/25

Number of Clinical Hours Today: __8__ Number of patients seen_**8**___

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

Preceptor: _Jill Michalak_____

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.

A total of 8 patients were seen as inpatients today for wound management:

-Right gluteus pressure injury stage 2 – cleanse with NS and comfort border every 3 days

-Paraplegic related to MVA 2024– right great toe trauma wound (healing – OTA), Right heel pressure injury (stage 2- comfort boarder), Sacral pressure injury (calcium alginate/comfort border every 3 days)

-Intubated unresponsive patient with multiple wounds from home, last known well was 7 days prior– pressure injury, DTI, traumatic, moisture-associated, and unstageable wounds (see below)

- Intubated septic shock patient with multiple wounds from the facility due to obstructive renal calculi– DTPI (monitor), pressure injury, MASD left axilla – fungal (antifungal powder), traumatic injury – great toe superficial – (OTA), Panus – MASD/superficial skin tear – (Medi honey and ABD pad)

- Laminectomy related to spondylolisthesis of the lumbar region – JP drain above incision, staples in tack, and 2 serous blisters around staples (draining) – (calcium alginate antimicrobial and cover with ABD dressing)

- Pressure injury to left upper back – chronic, superficial – (Vaseline/ABD daily)

- Breast reduction and tummy tuck overseas – consulted for abdominal and breast abscess – both superficial areas (Vaseline/ABD daily)

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- Consulted for right gluteal pressure injury and left great toe necrotic area – (betadine to toes, silicone foam dressing to gluteus every 3 days)

This patient is a 66-year-old female who was admitted yesterday to the ICU. She was transferred from a rural hospital after being found unresponsive at home. Her last known well was 7 days prior; she was found during a well check after the family did not hear from her. She is currently intubated, on bedside dialysis, and on EEG monitoring in place. Diagnosis includes septic shock, rhabdomyolysis, PE, AKI, TIA, HTN, leukocytosis, and pancreatitis.

Wound care was consulted for the following skin conditions, and assessment completed as follows: Labia majora unstageable wound -L – 6.3x W 4.2 x D-0 wound bed is necrotic, no drainage, surrounding tissue is erythema and blanchable, no odor.

Left groin friction/MASD – block measurement - L 14x W 6.3 x D-0 skin has areas of erosion, erythema, maroon, and some areas are blanchable. No drainage or odor.

Upper left lateral abdominal wound unstageable – W 14 x L 11x D-0. Wound bed with slough, surrounding tissue is erythematous and non-blanchable.

Inferior left breast fold and upper abdomen DTPI/MASD/unstageable wound– block measurement -W-10.2 x L 23 x D-0 – wound bed is necrotic, surrounding tissue is maroon, non-blanchable, no drainage

Left elbow DTPI – area is non-blanchable and maroon in color, surrounding area intact, color normal for ethnicity

DTPI to the left upper and mid abdomen, areas are maroon in color, surrounding tissues intact, and normal color for ethnicity.

The patient's wounds were assessed, measured, and cleansed with NS at the bedside. The patient remains intubated and sedated through the entire process. Wound care orders were written for staff to carry out. Her Braden score was an 8, which increases her risk for further skin breakdown and poor wound healing. She is currently on a pressure redistribution mattress and is being repositioned every 2 hours by staff with a skin check with each turn. She is currently an NPO without any form of nutrition currently however, she does have an order for hospice consultation due to her poor prognosis. No wound debridement was completed at bedside due to her current critical condition and hospice consultation.

Much improved – try to use a validated scale for pain when able, this is best for tracking purposes and is objective.

WOC nurses function as consultants and develop plans of care (POC) for other caregivers 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	3
Activity	1
Mobility	1
Nutrition	1
Friction/Shear	1
Total	8

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)

-Leave DTPIs open to the air and continue to monitor areas while keeping skin clean, applying a thin layer of Eucerin moisturizing cream to intact skin daily. ←*make sure this is clear, there is topical treatment*
-Clean left elbow DTPI with NS and apply a Mepilex silicone-border 6x8 dressing for protection and change every 3 days and as needed.
-Cleanse left groin friction/MASD with NS, pat dry, and apply adaptic oil emulsion non-adherent dressing to wound bed and cover with ABD to be changed daily.
-Cleanse the left lateral abdomen unstageable wound with NS, pat dry, apply a thin layer of Silvadene cream, and cover with ABD daily. (This is the treatment of choice for the preceptor to remove dead skin)
-Cleanse the inferior left breast fold and upper abdomen DTPI/MASD/Wound with NS, pat dry, and apply a thin layer of Silvadene and cover with ABD daily. (This is the treatment of choice for the preceptor)
-Cleanse unstageable pressure injury to the groin with NS, pat dry, and apply a thin layer of Silvadene and cover with ABD daily. (This is the treatment of choice for the preceptor). ← *as you are directing care, stare what you would do as the specialist here using your knowledge and resources. We know there are many ways to reach the same goal.*

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My order would be as follows:
-Cleanse left lateral abdomen unstageable wound with NS, pat dry and apply a nickel-sized amount of Santyl directly to the wound bed, cover with a moistened NS 2/2 gauze and ABD, change once daily.
-Cleanse the inferior left breast fold and upper abdomen DTPI/MASD/Wound with NS, pat dry, apply a nickel-sized amount of Santyl to the wound bed only, cover with moistened NS 2/2 gauze and ABD pad. Change once daily.
-Cleanse unstageable pressure injury to the groin with NS, pat dry, and apply a nickel-sized amount of Santyl to the wound bed only, cover with moistened NS 2/2 gauze and ABD pad. Change daily. *good*

Consult a nutritionist for evaluation of nutrition status pending hospice consult and decision.
Continue the use of a pressure-alleviating mattress. ←*be specific*
Continue to turn and reposition the patient every 2 hours and complete a skin check with each turning. ←*make sure the patient is not positioned over wounds.*

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

This was a very extensive patient with multiple skin issues. I believe that this is a good plan for her skin issues, which should be monitored carefully and re-evaluated as needed to make sure all her needs are met. Staff continue to keep the skin clean and dry and turn and reposition the patient per policy to prevent any further skin issues. The goal currently is infection prevention and comfort; the patient currently has a referral for hospice services. My wound care orders would differ from my preceptor's with the use of Silvadene cream. While it is an option, it is not the most suitable option for her wounds. I would use Santyl ointment daily for debridement instead, as well as moisten gauze in NS and ABD pads.

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

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What was your goal for the day?
My goals for today were wound debridement, hyperbaric chamber, and obtaining wound culture. I did not meet my goals for today because of the patient population we had. However, I did learn about the selection of wound care products.

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

My goal for tomorrow includes obtaining a wound culture and continuing to learn about different dressing options.

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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	✓	

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Hi Terryann – these revisions are much more on track. Continue to model submissions after this journal and feedback. Looking forward to your next submission, no further work is needed on this journal.
As usual, reach out with any further questions!
-Mike

Reviewed by: ____Mike Klements 11/28/2025_____

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