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: _11/25/25

Number of Clinical Hours Today: _8___ Number of patients seen__**11**__

Care Setting: Hospital ____ Ambulatory Care __X__ 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.

-60-year-old male with 2 wounds to the right medial ankle related to trauma – reports that he hit his leg on the bed frame. History of prior venous ulcer. Currently on Doxycycline, wound debride with a 4mm curette, alginate to wound bed, apply ABD, tubi grip, and elevate extremity.

-58-year-old with left lateral foot diabetic ulcer and peri-wound callus. Diabetic uncontrolled with an A1C above 9 (non-compliant with management). Wound debridement and callus removal with a 4mm curette. Current treatment: moist-moist gauze with VASHE, covered with ABD.

- 68-year-old male with a chemical burn to the right lateral wound. New to the wound clinic after seeing a dermatologist on 10/31 for a spot on his leg, he thought it might be cancerous. Chemical (not sure what) was applied to remove the area, and he ended up with a wound. Currently using Vaseline and dry gauze. Order changed to VASHE cleans, tetracycline topical ATB, and ABD pad twice daily.

- 80-year-old male with a chronic venous stasis ulcer on his left ankle. Reports that he has had this wound recurring for about 40 years. It recurs every 2-5 years, and the current treatment of mirragen/Versatel/ABD. Plan to continue current treatment and use Cavilon Barrier Film on the peri-wound.

-72-year-old type 1 diabetic male. He presents with a right AKA pressure injury that is healing and being packed with idiofoam. Packing was replaced by calcium alginate; the plan is for possible revision surgery to shave the bone to promote healing. He also has a left lateral heel pressure injury. Peri-wound is erythematosus, and the wound bed is positive for slough and odor. Wound culture collected, wound debridement completed with a 4 mm curette, and non-viable peri wound tissue removed with a pick-up and scissors. Plan to start ¼ Dakin's solution moist gauze and cover with ABD pads twice daily. Doxycycline twice daily for 10 days.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

- 72-year-old male with a diabetic surgical wound. Amputation of his fingers on his right hand, the patient chewed on his fingers during COVID isolation and ended up with amputation. Small wound to the right lateral hand with moist-to-moist VASHE and ABD twice daily. He also has 2 wounds to his right, AKA site 1 lateral and 1 anterior. Sharpe debridement was completed with a curette to remove slough and necrotic tissue. The patient has good blood flow; silver nitrate was used to cauterize bleeding. Currently using VASHE moist-moist and ABD twice daily, the caregiver reports that the wound remains too dry and painful. New order after debridement is to add plurogel to the wound bed, VASHE moist-moist, and ABD.

-52-year-old female with chronic right medial ankle chronic non-pressure ulcer. Wound bed has slough that was debrided with a 4 mm curette, current treatment is moist to moist VASHE and ABD. The patient has had a wound since 2023; she had flap repair in the past, and it failed. Patient is a current smoker; it was recommended that she quit smoking before any other procedures can be done, but she refused to quit. She is not a candidate for IV ATB due to her history of drug use. Plan is to continue VASHE moist-moist and ABD, follow-up in 3 weeks.

- A 70-year-old male diabetic new patient who fell a few weeks ago while going into the shower, which ended up with a skin tear to his right lower leg from a metal bar in the shower. Went to the ER, flap replaced with steri-strip, and treated with ATB. Wound edge not approximate, sharp debridement completed. Plan is to clean with VASHE, apply calcium alginate to the open wound, cover with adaptic, and ABD with single-layer tubi-grip every other day.

-A 62-year-old female presented as a new patient for a DTI to the right heel. Patient reports a large fluid-filled blister ruptured. Skin remains intact; they have been using silicone border dressing. Plan is cavilon skin prep to heel, cover with silicone border dressing for protection, and offload heel.

- 82-year-old female for colostomy check. The patient had a transverse loop colostomy related to small bowel obstruction from small intestine cancer. She was using a flat ostomy ring prior and developing skin damage around her stoma from a leak. She was switched to a convex system, ostomy ring, crusting method with stoma powder, and Cavilon skin prep and strip for an extra seal of the ostomy pouch and barrier strip to fill the abdominal crease.

-51-year-old male for wound check for his diabetic wound, wound to his right metatarsal area. He has

a medical history of type 2 diabetes (A1C of 7.2), hyperlipidemia, hypertension, and diabetic neuropathy. Patient reports that he lost sensation in his foot about 5 years ago. He has not been doing any diabetic foot checks over the years before finding this wound in September of this year. He reports that he works in automotive and wears a hard boot every day. He reports that he stepped on something and did not realize it due to his neuropathy. Once he discovered a wound, he went to the ER on 09/14 and had surgery on Sunday. He reports that after his surgery, he was placed on IV ATB from an infectious disease provider, and once that was finished, he never had a follow-up with ID or any more ATB. He was seen in the clinic 2 weeks ago for a wound check and debridement and was instructed to use VASHE moist-moist dressing with ABD and change twice daily. He reports that he is not wearing any offloading boots but has been elevating his foot at work.

Today, his wound was numb with ELMA numbing spray and debrided of slough to the wound bed using a 4 mm curette. Wound bed with friable granulation tissue, wound edges intact and erythematous, moderate drainage, and edematous without odor. W- 3.5 cm, L – 2.3 cm, and a depth of 3 cm to the bone. Bone fragments are present in the wound bed, and bone culture was collected to rule out osteomyelitis. Patient tolerated the procedure well, with no pain due to his neuropathy and numbing agent. Braden's score is 19; he reports that he does eat a healthy diet with protein and an appropriate amount of carbohydrates, as well as managing his blood sugar daily.

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.

Cleveland Clinic

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

Chart note:

Braden Risk Assessment Tool

Sensory Perception	1
Moisture	4
Activity	4
Mobility	4
Nutrition	3
Friction/Shear	3
Total	19

Patient is independent with mobility, with sensory impairment related to diabetic neuropathy. Continue to monitor feet daily for any new skin issues and refer to a podiatrist for diabetic shoes and foot care. No concern for moisture and mobility currently. Continue with normal activities as tolerated, elevating feet to reduce swelling and pain. Consult a nutritionist for dietary management to promote wound healing. Complete dressing changes as ordered and apply dressing to reduce friction between wound and footwear.

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)

Apply VASHE moist to moist 2 x 2 gauze to the diabetic wound in the right metatarsal area and cover with ABD twice daily.
Start oral Doxycycline capsule 100 mg twice daily for 10 days.
Complete X-ray of the right metatarsal area to rule out osteomyelitis.
Follow-up in the clinic in 1 week for wound re-evaluation.
Consult a podiatrist for a diabetic shoe evaluation to offload the wound and promote healing
Consult with a dietitian for dietary management to promote a healthy lifestyle, control diabetes, and support wound healing.
Another dressing option would be:
Cleanse the wound with VASHE, cut the gentian violet foam dressing to fit the wound, apply it to the wound only, and cover with an ABD dressing; change every 3 days.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Cleveland Clinic

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

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

Appropriate assessment of the wound was complete, and I agree with this. An outpatient X-ray was ordered as well. The only thing that I would have done differently was to send him to the ER after completing my assessment instead of ordering an outpatient X-ray. If this is not completed promptly, this can delay care if the patient is not compliant with instructions. After checking his medical records, it showed that he went straight to get his X-ray, and the result came back promptly. He was diagnosed with Osteomyelitis and was contacted before the end of the shift and instructed to report to the ER. He stated that he was heading there today to prevent any amputation of his toe.

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?

My goals were to complete wound culture and different dressing options. Yes, my goals for today were met; we completed a bone culture, wound culture, and multiple different dressing options.

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

Completed 3 wound clinicals

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	✓	

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.