Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: _Rebecca Doucette Day/Date: Friday 12-5-25

Number of Clinical Hours Today: _9___ Number of patients seen__**5**__

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

Preceptor: _____Elizabeth Kulling_____

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.

We saw 5 patients today and keep a running conversation about another patient whom we did not evaluate but helped facilitate ordering a wound vac for for discharge. The first patient we saw was a 43 y/o male with hx of carcinomatosis, rectal cancer and crohns with a urostomy and colostomy. We were consulted for a leaking urostomy pouch which we changed to a ConvaTec Flat Durahesive system. We also modified the colostomy pouch system when we changed it so it was more flexible by adding radial slits to the barrier outside edges. Step by step instructions were also written and provided for anticipated discharge. The second patient we saw was a 40 y/o male for NPWT dressing change to a subxiphoid wound. We ended up waiting almost an hour before we could begin his NPWT dressing change in order to get him an order for pain medication that he requested prior to dressing removal as his previous experiences had been very uncomfortable. Once that was accomplished we were able to change the dressing and my preceptor discussed the appropriate amount of foam needed to place in the wound; the previous one appeared too large and was likely contributing to discomfort and not aiding in healing. The third patient we saw was a 48 y/o male with a wound in his right groin from a previous I&D of a fluid collection. The only thing we changed with this was reducing the amount of drape material used and were successful in obtaining and good seal. He also had a small wound distal to this that we applied allevyn foam gauze with silicone border. The fourth patient we saw was a 67 y/o male with an abdominal wound adjacent to his driveline exit site that required a change in his NPWT dressing. This was interesting to remove as great care was required to free the driveline from the drape adhesive. Once free we cleaned the site and gently irrigated it and was able to measure and determine tunneling and undermining around the wound edges. A new dressing was then placed and seal obtained. The fifth patient we saw was an isolated intestinal transplant patient with a new chimney ileostomy. This was a simple pouch change, her peristomal skin intact and contours even not requiring anything other that a cera ring and the pouch system.

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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	4
Moisture	4
Activity	3
Mobility	4
Nutrition	3
Friction/Shear	3
Total	21

67 y/o male pmh of CAD, PCI, atherosclerosis of native artery of both lower extremities with intermittent claudication, carotid stenosis, hypertensive kidney disease with CKD stage IV, Iliac artery stenosis, HFrEH had a LVAD placed this admission and subsequently developed infection of LVAD driveline requiring an I&D and debridement. The surgical incision was made over the driveline into a sinus extending deeply into the mediastinum exposing chronically infected tissued with moderate amount of pus and debridement along the sinus track. WOC consulted for NPWT dressing change scheduled for today, prior dressing placed by CTS team.

Pt awake and alert, conversant with staff, reports was premedicated prior to dressing change with oral pain medication and agreeable for dressing change at this time. Wound location: abdominal driveline exit site. Measures 3.1cmx 2.8cmx 1.8cm undermining at 9-5o'clock 1.2 cm, tunnel following driveline at 11o'clock 3.6cm. Wound bed with 100% granulation tissue. Wound edges irregular. Periwound skin with erythema circumferentially. Minimal serosanguinous drainage. No odor.

Skin cleansed and dried and no sting skin prep applied; wound bed irrigated with NS. Hollihesive under driveline and at superior aspect of wound applied with transparent dressing picture framed to periwound skin. Black foam cut to fit wound bed; 2 pieces of foam to wound bed, negative pressure applied at -100mmhg,low continuous pressure: adequate suction achieved, no leaks detected, no foam in contact with skin.

All questions addressed and patient comfortable at this time.

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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)

Determine if patient requires pain medication prior to dressing change and account for time of onset.
Clamp tubing and turn off the wound vac, measure output in canister and discard if scheduled to change (weekly).
Apply skin adhesive remover and gently remove transparent film dressing taking care to stabilize driveline and not pull when peeling off dressing.
Apply saline to the foam gauze if needed when removing to help decrease discomfort.
Irrigate wound bed gently with NS.
Wash periwound skin with hibiclens and rinse and allow to dry.
Apply Esenta no sting skin barrier prep
Cut Hollihesive in rectangular piece and place under driveline and place another piece at the superior aspect of the wound. Use the transparent drape dressing and picture frame around the periwound skin.
Fabricate a piece of black foam to fit in the wound bed. Cut another piece to allow space for tract pad placement assure no foam in direct contact with skin.
Apply tract pad and apply another transparent film over to include a portion of the driveline to ensure a good seal.
Connect tubing to wound vac and turn on setting to -100mmgh assure adequate suction with no leaks. F
Label dressing with number of foam pieces and date.
If wound vac losses seal and is off for greater than two hours dressing will require change.
Review with patient alarms for vac and to notify staff if not functioning properly.

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

I thought the proximity of the driveline made this more challenging than some of the other dressings we have done so far. Removing the old dressing and obtaining a seal required a little more finesse around the driveline, but with patience it was achievable. I thought trying to minimize the footprint of the drape was helpful for the patient so he didn't have to endure as much removal next dressing change. The dressing itself I think was good and not too many extra steps and the Hollihesive very appropriate to help prevent pressure injury from the driveline. I would have liked to discuss with him a bit more about his diet and steps to help increase his healing potential as well as probiotics and food choices that have probiotics in them given the fact that he is on antibiotics and will be for a considerable period of time.

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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 do more wound care and NPWT which we were able to accomplish.
What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) On Monday I would like to see the patient from 12/4 with the fistula for his pouch change to assess how that system held up and if the new preceptor I am with has other suggestions for this pouching.

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	✓	
• 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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