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: Tuesday 12-9-25_

Number of Clinical Hours Today: 8____ Number of patients seen ___**4**_

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

Preceptor: Helen Shubsda_____

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 I was with Helen Shubsda in wound care, we started the day discussing Wound Vision Thermal imaging and skin failure diagnosis criteria. We also looked at different supplies in the stock room to become familiar with the formulary. We attended a meeting with the WOC team reviewing the 2026 calendar monthly educational sessions the WOC team will be doing with hospital nursing staff for wound and ostomy care. After that we saw 4 inpatients for wound consults.

The first patient we saw was a 29 y/o female with a hx of GBM in the ICU with multi organ failure. She had multiple wounds; 2 midline abdominal incision wounds with serosanguinous drainage, two right sided partial thickness abdominal wounds and scattered left sided abdominal blistering partial thickness wounds that were healing. She also had a wound of unknow etiology to her anterior right forearm and bilateral medial knees. Her ischium had a partial thickness wound with irritant contact dermatitis blistering from edema. We washed her wounds with NS and the incisional wounds with Vashe and used Aquacel on the incisional wounds and covered with an ABD pad. The other abdominal wounds were covered with Urgotul and covered with ABD pad. The ischium was cleansed and barrier ointment applied. Preventative measures in place were the TruVue heel protectors, T&P every two hours with wedges for positioning, and a low air loss mattress surface.

The second patient was a 44 y/o who had cardiac surgery and required a ring to be removed in the OR from his right ring finger resulted in a wound to the anterior aspect of the digit. We assessed the wound and provided contact layer with urgotul and then aquacel followed by gauze and light coban wrap. The third patient was a 77 y/o male on the step down unit we evaluated for a coccyx wound that was an irritant contact dermatitis due to moisture. He was independent and mobile we educated him on offloading the site and changing positions frequently and recommended barrier cream Critic-aid. Similar preventative measures recommended for heel protectors and low air loss mattress. The fourth patient was a 75 y/o male in the cardiac icu on ECMO and hemodialysis consulted for wound to right calf from a previous drain site and bilateral full thickness ear wounds from mechanical devices. Skin barrier ointment was recommended for the

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ears and removing external pressure from devices. The right calf wound was small < 1cm with moderate serous drainage with periwound skin intact with edema. We cleansed the wound with ns and applied aquacel and abd pad dressing. After seeing the patients we attended a virtual meeting regarding the Bard Dignishield fecal management system trial and survey results from the nursing staff.

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

44 y/o male with pmh of asthma, tobacco use and umbilical hernia repair, presented 12/5 to outside hospital ED with multiple syncopal episodes found to have a thrombus in the ascending aorta with wedge renal infarcts. He was transferred to main campus hospital and had ascending aorta replacement LAA. While in the OR, pt's ring had to be cut from his 4th right ring finger resulting in a wound to the proximal portion of the anterior 4th phalanx that WCCT is being asked to evaluate today.
Pt is pleasant, alert and oriented x 3 in no distress sitting up in bed. Dressing to right ring finger removed.
Full thickness irregular wound anterior proximal phalanx measuring 1.5cm x 1cm x 0.1cm wound base yellow/slough no drainage or odor with peri wound skin macerated and white.
Wound was cleansed with Vashe solution and gently dried, Urgotul contact layer placed followed by Aquacel and covered with gauze and light coban wrap.
Pt declined any further skin assessment at this time.
Reviewed with pt need to keep wound clean and dry and recommended dressing change daily with outpatient follow up when discharged home if not fully healed.

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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)

Left Ring finger wound treatment:
Remove dressing gently
Cleanse wound with Vashe soaked gauze, wring to remove excess solution and apply gauze to wound bed and allow to soak 5-10 minutes. Remove gauze and gently dry
Apply Urgotul contact layer over wound as a contact layer and then apply Aquacel and cover that with a gauze and secure with a light coban wrap.
Reviewed with pt need to keep wound clean and dry.
Dressing change daily or sooner if needed.
WCCT will continue to follow patient reconsult sooner if wound worsens.

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

This patient had a unique wound to the finger that has the potential for complications if it becomes infected as the proximity to extensor tendon is quite close. I thought cleansing the wound with Vashe was a good idea and given the moist appearance the contact layer with Urgotul followed by Aquacel was appropriate. If those supplies were not available and alternative dressing could be a nonstick alginate gauze and wrapped with kerlix.
I also would have assessed and documented the ROM of the digit to at least have as a baseline and asked about his tetanus vaccination status.

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?

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I would like to evaluate more wounds and be able to select appropriate dressings which I was able to do for a few different wound types.
What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)** Tomorrow I would like to continue with wound assessment skills differentiating between moisture and pressure related injuries.

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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