Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ____Scott Strazzella_____ Day/Date: __12/30/25_____

Number of Clinical Hours Today: ___8__ Number of patients seen__**4**__

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

Preceptor: _Moira Garrity (Wilmington)_____

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 in clinicals we saw 4 patients with different types of wounds. We saw a 77-year-old gentleman who has ambulatory disfunction and spends much of his time sitting in a chair or lying in bed, dealing with BLE chronic venous ulcers. The next patient had a diabetic ulcer to the plantar area of his left foot with a dry, hard callus for which a recommendation for a podiatry consultation was made for possible debridement of the wound. Recommendations were made by WOC to offload the foot until seen by Podiatry. My preceptor and I saw a gentleman in the Neuro ICU for skin tears to his left arm, who was intubated and unresponsive due to a stroke at home. The wound was cleansed with normal saline, patted dry, and Mepitel One silicone dressing was applied. The left arm was elevated with a pillow due to edema. Lastly, I saw a gentleman s/p left BKA who had a stage II pressure injury to his stump due to a poorly fitting prosthetic leg due to weight loss. The wound was cleansed with normal saline, Medihoney sheet was applied to wound with a gauze pad, wrapped in Kerlix. It was recommended to elevate the left leg to control any edema while in bed. The patient stated he was in the process of getting a new prosthetic leg that fits properly. After documentation, my preceptor and I did photo validations for new patients on the WOC list. We also completed an inventory of wound care supplies in the WOC office.

Types of patients: Diabetic Ulcer, Venous insufficiency ulcers, skin tears, Pressure injury to left BKA

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

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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	2
Moisture	3
Activity	3
Mobility	2
Nutrition	3
Friction/Shear	3
Total	16

Patient is a 69-yr-old female presents to the emergency department secondary to concerns regarding palpitations and confusion. In the ED, patients found to be febrile with temp at 39.4 C and elevated RR. Urinalysis in the ED was grossly positive for UTI leading to sepsis. Patient has a past medical history for CVA with left side weakness and aphasia, CKD, CAD status post CABG, type 2 diabetes with recent history of pulmonary embolus and hypertension, and chronic sacral wound. Wound care RN consulted for dressing recommendations for sacral ulcer. WOC introduced themselves to the patient, patient had some difficulty communicating due to her aphasia and needed assistance turning due to left sided weakness. Evaluation of the sacrum revealed an unstageable sacral wound measuring 3.2cm X 2.5cm with necrotic tissue and yellow slough in the wound bed. The wound had moderate purulent drainage with a strong foul odor. Wound edges were attached to wound bed. Periwound with erythema and pink scarring surrounding wound, no induration or fluctuant. WOC cleansed wound with ¼ strength Dakin's solution, applied ¼ strength Dakin's solution moist 4x4 gauze pad to wound bed and covered wound with ABD pad secondary dressing, secured with paper tape. Patient was offloaded using a foam wedge to relieve pressure on her pressure injury. WOC placed an order for wound to be cleaned with ¼ strength Dakin's Solution, Santyl was ordered as an enzymatic debriding agent. Cover wound with Dakin's moist 4x4 gauze, an ABD pad as a secondary dressing, secured with paper tape. This dressing was ordered to be changed daily. WOC ordered a low air loss mattress to relieve pressure on patient's pressure injury. Also, WOC recommended to bedside RN to have physicians place a consult for general surgery to evaluate wound for possible sharp debridement and a nutrition evaluation to ensure patient has enough protein intake for adequate wound healing. WOC also placed a referral for wound clinic evaluation for treatments after discharge. WOC communicated to bedside RN the treatments that were completed and the intended orders that WOC would place.

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)

- Gather supplies including changing pad, ¼ strength Dakin's solution, Tube of Santyl Ointment,

gloves, 4x4 gauze pads, scissors, ABD pad, paper tape, turn wedge and Vocera phone for photos

- Clean hands before entering room with hand sanitizer
- Introduce yourself as a WOC nurse and the purpose of the visit.
- Put on clean latex free gloves
- Raise patient bed to a comfortable working level
- Turn patient on her left side
- Place changing pad under working area on bed to protect bed sheets.
- Remove and inspect old dressing
- Clean wound with ¼ strength Dakin's solution, pat dry with 4x4 gauze pads
- Take photos of the wound for chart
- Apply a nickel thick layer of Santyl to wound bed
- Moisten gauze 4x4 pads with ¼ strength Dakin's solution
- Place moistened 4x4 gauze pad over wound
- Cover wound with ABD pad
- Secure ABD pad with paper tape
- Turn patient using wedge every 2 hours
- Keep skin clean & dry
- Dressing to be changed daily
- Contact WOC via Vocera for any wound deterioration

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

In the future, due to the patient being slightly confused and with aphagia, I feel as though we could have reached out to a family member, if possible, to see if the patient would have the ability to be transported to a wound clinic several times per week for further treatment post discharge from 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?

My goal for the day was to provide treatment to a pressure injury. My goal was met.

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

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I am hoping to exchange a suprapubic catheter

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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