Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: _Crystal Wilson_____ Day/Date: Monday 1/5/2026___

Number of Clinical Hours Today: _8___ Number of patients seen____

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

Preceptor: _Erica Yates_____

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.

I saw five in-patient wound care patients today with my preceptor. All patients were being followed for wound-related concerns, including pressure injuries, surgical/traumatic wounds, and complex infectious wounds. The first patient had a Stage 4 pressure injury to the coccyx that has been worsening. The wound had circumferential undermining with the deepest point noted at the 5 o'clock position. The wound was cleansed with normal saline, lightly packed with Aquacel, and covered with a foam dressing. The second patient had a chronic non–pressure related wound to the left lower leg that originated as a traumatic hematoma and progressed, requiring two surgical debridements. This patient was selected for my chart note and plan of care (more details below). The third patient had a history of necrotizing fasciitis of the left inner groin. My preceptor showed me photographs from the time of hospital admission, which demonstrated significant tissue involvement. At today's visit, the wound was nearly healed but had moderate yellow drainage and was uncovered on assessment. Aquacel was applied to assist with absorption and covered with a foam dressing. The fourth patient was a younger patient with a history of cancer and multiple surgeries who had an unstageable pressure injury to the left buttock. The wound bed was completely covered with yellow and black slough/eschar tissue. Hydrogel was applied to promote autolytic debridement and covered with a foam dressing. The final patient was an elderly male admitted for a planned left foot surgery. Due to diabetes and vascular impairment, the 3rd and 4th toes of the left foot were necrotic; however, these were not assessed due to impending surgery. We assessed his left hip unstageable pressure injury, which was covered with soft, adhered yellow slough and was dry with minimal drainage. Hydrogel was applied and covered with a foam dressing.

Types of patients seen

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- In-patient wound care patients
- Pressure injuries (3 patients)
- Necrotizing fasciitis wound (1 patient)
- Traumatic/surgical wound (1 patient)

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	3
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	2
Total	18

This is the initial visit for an 80-year-old female with a history of achalasia and dysphagia, admitted on 1/5 for management of these conditions. The patient sustained trauma to the left lower leg several months ago, which progressed to a large hematoma requiring surgical intervention. She is status post surgical debridement with placement of NovoSorb BTM on 11/21 and has been managed with NPWT since that time, with dressing changes every three days. The patient follows with a wound healing center at an outside hospital. WOC service was consulted for wound care recommendations during this admission.

On assessment, the left lower leg wound was dry. NovoSorb BTM remained in place over the majority of the wound bed, giving the wound a yellow appearance. The visible wound bed was pink and red. Wound measurements were 14 cm x 11.5 cm x 0.1 cm. No drainage or odor was noted, and the patient denied pain.

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Given the lack of drainage, minimal depth, and dry wound bed, NPWT was not felt to be appropriate at this time. This was discussed with the patient, and she was agreeable to discontinuation of NPWT after education was provided.

Interventions included removal of the old dressing, cleansing the wound with normal saline, and patting dry. A thin layer of hydrogel was applied to the wound bed, followed by placement of a Urgotul contact layer, covered with an ABD pad and secured with rolled gauze and paper tape. Dressing change frequency was ordered daily and as needed.

The patient's Braden score was 18 (sensory perception 4, moisture 3, activity 3, mobility 3, nutrition 3, friction/shear 2). Prevention measures were ordered, including an IsoTour blower for low air loss, bilateral heel suspension boots, glide sheet and turning wedges for Q2-hour repositioning, and a nutrition consult due to dysphagia and reliance on Corpak feeding. WCCT will continue to follow weekly.

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 lower leg full-thickness surgical wound:**
  Remove old dressing. Cleanse wound with normal saline or wound cleanser and pat dry. Apply a thin layer of hydrogel to wound bed. Apply Urgotul contact layer. Cover with ABD pad and secure with Kerlix. Change dressing daily and as needed.
- Order IsoTour blower for low air loss mattress support
- Obtain Tru-Vue heel protectors to bilateral lower extremities for heel offloading
- Obtain Medline Comfort Glide Sheet and turning wedges; reposition patient every 2 hours
- Nutrition consult for optimal wound healing
- Continue skin prevention interventions based on Braden risk assessment subset scores

- WCCT to follow weekly; reconsult if wound worsens or status changes

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

I felt the care provided to this patient was thorough and patient-centered. The patient was actively involved in decision-making, and education was provided regarding the change in wound management strategy. I agreed with discontinuing NPWT given the dry wound bed, minimal depth, and lack of drainage, as well as the dressing selected to promote moist wound healing.

The only aspect I would have approached differently would have been researching NovoSorb BTM prior to seeing the patient. Upon removing the dressing, it was clear there was a graft-like material present that my preceptor and I were not previously familiar with. We appropriately left it in place and performed care over the graft. After returning to the office, we reviewed information on NovoSorb BTM and learned that it is intended to remain in place for an extended period following placement. Reviewing this prior to the visit would have allowed for more detailed patient education at the bedside.

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 observe how an in-patient WOC APRN manages their day, prioritizes consults, and develops treatment plans for a variety of wound etiologies. As this was my first clinical day, I also wanted to absorb as much information as possible. This goal was met, as I was able to observe multiple complex wound types, see how consultations are approached, and better understand the flow of an in-patient wound service.

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

My learning goal for tomorrow is to further develop my wound assessment skills by independently identifying wound etiology, tissue type, drainage characteristics, and appropriate dressing selection, and to actively participate in formulating the plan of care with my preceptor.

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	✔	

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Learning goal identified	✔	

Reviewed by: _____ Date: _____

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