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: Wed. 1/7/2026

Number of Clinical Hours Today: 8 Number of patients seen 4

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.

Today my preceptor and I saw four inpatient wound care patients. We began the day by attending a staff meeting, which lasted approximately 30 minutes and focused on patient flow, consult prioritization, and interdisciplinary communication. The first patient, who was selected for my chart note, was an ICU patient with an unstageable pressure injury to the sacrum that had progressed. Additional details are outlined below. The second patient was a follow-up with an unstageable pressure injury to the coccyx with a significant incontinence-associated dermatitis (IAD) component. The primary wound bed was largely covered with yellow slough, while the periwound skin demonstrated blanchable erythema, peeling, scattered superficial openings, maceration, and moisture due to stool incontinence. This patient had an indwelling Foley catheter in place. Due to the wet wound environment and periwound maceration, after cleansing with wound cleanser, a hydrofiber dressing (Aquacel) was applied and covered with a foam dressing (Allevyn), to be changed daily and as needed. The patient had turning wedges in place and was compliant with every-two-hour turning and repositioning. The third patient was a follow-up for bilateral heel wounds. The right heel wound was healed. The left heel wound remained an unstageable pressure injury that initially presented as a deep tissue pressure injury (DTPI), subsequently opened with drainage, and is now dry with adhered, firm black eschar. After cleansing with normal saline and gauze, skin prep was applied, followed by a contact layer (Urgotul) and a foam dressing (Allevyn), to be changed daily. The patient was not wearing heel suspension boots upon entering the room; education was provided on the importance of wearing heel protectors at all times while in bed, and the boots were applied following wound care. The fourth patient was a follow-up for a posterior scalp wound that originated as a DTPI and progressed to an unstageable pressure injury. The wound was covered with adherent, dry black eschar and had no drainage. Hydrogel and a foam dressing had been previously ordered. During today's visit, my preceptor gently removed a portion of the eschar, revealing healed epithelial tissue beneath, while some adhered eschar remained. After cleansing

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with normal saline and gauze, the existing order was continued with application of a thin layer of hydrogel and coverage with an Allevyn foam dressing, to be changed daily. In addition to patient care, I attended an educational session on the Scout imaging device, which uses multispectral imaging to evaluate tissue beneath intact skin and assist with the assessment of suspected DTPIs. This was my first exposure to this technology and enhanced my understanding of early pressure injury detection.

Types of patients seen:

- Pressure injury to the sacrum
- Pressure injury to the coccyx with IAD patient
- Pressure injuries to the bilateral heels
- Pressure injury to the posterior head

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	1
Moisture	3
Activity	1
Mobility	1
Nutrition	3
Friction/Shear	1
Total	10

This is an 80-year-old female admitted for acute complications related to a myocardial infarction. The inpatient Wound Care and Continence Team (WCCT) was consulted for evaluation and management of a sacral wound. Review of prior images indicated the patient was admitted with an unstageable pressure injury to the sacrum, initially suspected to be a stage 2; however, further assessment ruled this out. On today's assessment, the sacral wound is a stage 4 pressure injury. The wound is partially covered with fibrinous yellow and tan slough tissue, with portions hanging from the wound bed. The visible wound bed is pink and

yellow, with exposed bone present. The wound measures 9.5 cm x 7 cm x 1 cm, with circumferential undermining and a maximum undermining depth of 1.2 cm at the 11 o'clock position. The periwound skin demonstrates blanchable erythema. A moderate amount of yellow and serosanguineous drainage was noted. The patient is intubated and unable to verbally report pain. Nonverbal pain indicators were assessed, including facial expression, vital signs, and ventilator compliance, with no overt signs of distress observed during wound care. Given the extent of tissue involvement and presence of devitalized tissue with exposed bone, WCCT consulted Plastic Surgery for evaluation and debridement. The patient's Braden score is 10, indicating high risk for pressure injury. She is currently on a low-air-loss mattress, utilizes a turning and repositioning system with Q2 turns, has an ostomy and an indwelling Foley catheter to assist with moisture management, and is receiving total parenteral nutrition (TPN).

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)

Sacrum – Stage 4 Pressure Injury:

- Remove old dressing. Cleanse wound with normal saline or wound cleanser using gauze; pat dry. Apply Aquacel Hydrofiber Dressing to the wound bed. Cover with Allevyn Foam Dressing. Change dressing daily and as needed for saturation.
- Plastic Surgery was consulted for bedside debridement.

Pressure Injury Prevention / Support Surfaces:

- Maintain low air loss mattress at all times.
- Maintain the turning and repositioning system; reposition the patient every 2 hours to offload the sacral and ischial areas.
- Utilize lift equipment as needed to minimize friction and shear.

Heels:

- Maintain Tru-Vue heel protectors on both feet at all times while the patient is in bed.

Pain Management:

- Assess pain using an appropriate nonverbal pain scale prior to and during wound care; notify the primary team if signs of discomfort are observed.

Nutrition:

- Continue nutrition consult and TPN management to support optimal wound healing.

Skin Care:

- Continue skin prevention interventions based on Braden subscale scores.
- WCCT to follow weekly. Re-consult WCCT with any concerns, changes in wound status, or signs of deterioration.

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

The care provided to this patient was thorough and appropriate. Given her intubated status and immobility, a full head-to-toe skin assessment was completed, and all other skin areas were intact. The sacral wound was appropriately assessed, measured, and managed, and escalation to Plastic Surgery for debridement was warranted based on exposed bone and devitalized tissue. Nursing staff were already utilizing appropriate pressure injury prevention measures, including a low-air-loss mattress and scheduled repositioning.

The only aspect I would have approached differently was the debridement process. While my preceptor is trained to perform conservative sharp debridement, Plastic Surgery is consulted for all debridements when available. Observing a bedside conservative sharp debridement would have been a valuable learning opportunity. This experience reinforced the importance of early recognition of wound deterioration and timely interdisciplinary consultation to prevent further tissue destruction and systemic complications.

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 today was to increase my independence in developing complete WOC plans of care, including prevention strategies, patient and staff education points, and appropriate product selection, and to verbalize my clinical rationale confidently before confirming with my preceptor.

Was the goal met?

Yes. I was able to independently propose a comprehensive plan of care, including wound treatment, prevention strategies, and escalation to Plastic Surgery, and verbalize my clinical reasoning prior to

confirmation with my preceptor.

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

My goal for tomorrow is to strengthen my assessment skills in the outpatient WOC setting, understand the rationale behind treatment decisions, and participate hands-on where appropriate.

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	✔	

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● Identifies alternatives/what would have done differently	✔	
Learning goal identified	✔	

Reviewed by: _____ Date: _____

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