Cleveland Clinic

R. B. Turnbull Jr. WOC Nursing Education Program

Daily Journal Entry with Plan of Care & Chart Note

Student Name: __**Selena Perez**__ Day/Date: **1/6/26**

Number of Clinical Hours Today: **8**

Care Setting: Hospital **x** Ambulatory Care ____ Home Care ____ Other ___

Preceptor: **Shannon Johns**

Clinical Focus: Wound **X** Ostomy ____ Continence ____

Reflection: Describe your patient encounters & types of patients seen.

Today we saw six patients, one in the ED and five inpatient.

#1: New end sigmoid colostomy, POD#1. Outpatient colonoscopy resulted in perforated bowel, requiring emergency sx overnight and ostomy creation. Provided initial ostomy teaching, will follow up tomorrow for second day education (regular WON shift)

#2: New end colostomy, POD#2. LBO and umbilical hernia repair with creation of end colostomy. Patient was too lethargic POD#1 for teaching. Today provided initial ostomy education, will follow up tomorrow for second day education.

#3: L forearm IV infiltration. Significant bruising, swelling, with two small localized blisters. 'Believed' to be caused by extravasated levo two days prior, but nothing found in chart about IV placed in left arm although patient did receive levo gtt and calcium chloride IVP in the same day. CNS was notified and is investigating, pharmacy on board as well.

#4: Coccyx stage 3. Identified on admission, wound bed clean and moist with pink tissue, scant serosanguineous drainage.

#5: BLE follow up. Dressing change and re-evaluation done before patient discharges. No changes to order, venous wounds and cellulitis improving!

#6: L heel unstageable, hx poorly controlled T2DM, podiatry consulted and imaging and fresh A1C recommended to attending.

Types of patients seen: Colostomy education x2, IV extravasation, stage 3 PI, venous ulcers, cellulitis, PI/DFU

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Chart note:

Admitting dx: Generalized weakness, recurrent falls

Wound team consulted for evaluation and recommendations for left heel ulcer identified on admission. Patient hx T2DM, R BKA, diabetic neuropathy, L TMA, incontinence, cognitive communication disorder, and incontinence. L foot XR 1/4/26 negative for acute fracture or bone destruction, no suspicion of osteomyelitis. Patient guardian XX is involved, however not present at bedside at this time. A1C 4/9/2021 10.7%, ACHS with sliding scale ordered by attending. Patient receives home PT/OT, WCB at baseline. Pt is pleasant and agreeable to evaluation at this time.

Left heel 95% dry, thin, boggy eschar and 5% moist pink tissue; scant serosanguineous drainage from moist tissue located centrally within eschar. Wound measures 5.0x3.5, total area including periwound 6.5x7.0. Periwound boggy with localized ecchymosis and swelling. No purulence or erythema. Sour odor noted prior to and after cleansing with wound cleanser, patting dry. Betadine moistened Aquacel AG applied to the wound, covered with ABD pad and secured with Kerlix gauze roll and ACE wrap. Patient tolerated well and is unsure when the wound began or what may have caused it. Discussed importance of monitoring and maintaining blood glucose <180 mg/dL for proper wound healing.

Rt BKA assessed, stump is C/D/I.

Patient is chronically incontinent, currently on Stryker Isoflex mattress. LAL pump ordered, consider external urinary catheter for further moisture management. Recommend NO brief in bed. Recommend new A1C and diabetes disease management consult, attending notified. Podiatry was consulted on admission but not yet evaluated, appreciate recommendations. Due to patient's cognitive function, education, monitoring, and communicating with guardian is necessary for continued care. Orders placed for nursing staff to continue dressing change, wound team will continue to follow along as scheduling allows, please reach out with any questions or concerns.

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2
Activity	2
Mobility	3
Nutrition	3
Friction/Shear	2
Total	**14**

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 used)

Left heel

- Daily dressing change
- Cleanse wound with wound cleanser, pat dry
- Apply betadine moistened Aquacel AG, cover with ABD pad
- Secure dressing with Kerlix gauze roll and ACE wrap
- Offload heel with green TruVue heel protector boot when in bed
- Monitor for s/s of infection including: purulence, odor, erythema, swelling

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- If concern for infection, please notify attending physician and Inpatient Wound and Ostomy Team via Halo

Pressure injury prevention

- Turns/offloading q2 and as needed
- Offload heels with pillows or green boots
- Keep skin clean and dry, ensure LAL pump is plugged in, on, and connected to mattress
- Monitor areas of bony prominences q shift, assessing for discoloration, heat, and surrounding blood flow
- May utilize Allevyn silicone border foams over bony prominences for protection, change q5 days and PRN

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

I would have consulted nutrition in addition to the diabetes educator and disease management. I would have liked to have the guardian there at the time of eval, I think on our follow up it would benefit the patient to arrange guardian to be present. Having family/guardian there will also help to reorient the patient.

Goals

What was your goal for the day?

My goal from last clinical day was to see either a fungating wound or uncommon fistula tract. I did not meet this goal however I was able to provide more ostomy education x2 which I'm all for!

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

I would like to keep the same goals! Fungating wound and/or uncommon fistula.

Reviewed by: _____ Date: _____

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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		
● 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		

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● 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		

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