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: _Fri. 1/9/2026__

Number of Clinical Hours Today: _8__ Number of patients seen__**8**__

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

Preceptor: __Bobbi Jo Killing_____

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's clinical day was within the inpatient hospital setting. The day began with a multidisciplinary WOC team huddle to review patient assignments, acuity, and priorities. A total of eight patients were seen, representing a range of complex ostomy and wound care needs, including postoperative ostomy management, enterocutaneous fistula management, and negative pressure wound therapy (NPWT). Patient encounters included pouch changes for multiple ostomy types (end descending colostomy, loop ileostomy, end jejunostomy with mucous fistula, and enterocutaneous fistula). Clinical decision-making was required to determine when intubation and stimulation of a colostomy were not indicated based on adequate function. Several postoperative patients required rod removal or monitoring, and pain management considerations significantly impacted education timing and tolerance. Two ICU patients required extensive NPWT dressing changes to high-risk anatomical locations (right groin and sternum). These encounters reinforced the importance of teamwork, positioning, and adherence to pressure injury prevention strategies in critically ill, sedated patients. A consult patient with a high-output jejunostomy demonstrated improvement in confidence with pouching following prior education, highlighting the importance of reinforcement and progressive independence. Another patient with an enterocutaneous fistula required continued use of a gravity-drainage system due to high output, emphasizing fistula containment as a key component of skin protection and quality of life. Overall, the day reinforced the WOC nurse's consultative role, the importance of individualized plans of care, and the need for adaptability based on patient condition, pain, and readiness for learning.

Types of patients seen today included:

- Postoperative colostomy patient requiring pouch change and assessment for need for intubation/stimulation

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- Postoperative diverting loop ileostomy patient requiring rod removal and pouch change
- End jejunostomy with mucous fistula experiencing high output and pouch leakage
- Patient with stage 4 sacral pressure injury managed with NPWT (more details in chart note)
- Two critically ill ICU patients with complex wounds (right groin and sternum) requiring NPWT dressing changes
- Postoperative IPAA with diverting loop ileostomy and rod in place
- Patient with chronic enterocutaneous fistula requiring weekly pouch change and gravity drainage

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	3
Moisture	3
Activity	1
Mobility	2
Nutrition	2
Friction/Shear	2
Total	13

Patient: 75-year-old male
Reason for Consult: Scheduled NPWT dressing change to sacral pressure injury

History & HPI:
The patient has a history of acute on chronic systolic and diastolic heart failure and has been hospitalized

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since September 3, 2025. During the course of hospitalization, he developed a stage 4 pressure injury to the sacrum. He is currently being managed with NPWT and was seen today for a scheduled dressing change.

Assessment & Encounter:
The patient was able to turn with assistance but required support to maintain position during the dressing change. His wife was present at the bedside and assisted with positioning, providing both physical and emotional support.

Wound Assessment:

- **Location:** Sacrum
- **Stage:** 4
- **Size:** 5.3 cm (L) x 5.5 cm (W) x 1.6 cm (D)
- **Undermining:** 3.5 cm from 8–5 o'clock
- **Wound Bed:** 75% red granulation tissue, 10% slough, 15% exposed bone
- **Wound Edges:** Flat
- **Periwound Skin:** Erythema present
- **Drainage:** Serosanguinous
- **Odor:** None noted
- **Pain:** Rated 2/10 during dressing change; patient tolerated procedure well

Interventions:

- Wound cleansed with normal saline. Periwound skin cleansed and dried thoroughly. One piece of UrgoTul placed over wound bed to protect exposed bone. One piece of black foam spiral-cut and bridged to right thigh. NPWT applied and resumed at continuous suction at 125 mmHg.

Evaluation:
Periwound skin integrity has significantly improved compared to prior assessments. Wound bed

demonstrates minimal interval change.

A Braden score of 13 places the patient at moderate risk for pressure injury development and delayed wound healing. This score supports the need for aggressive pressure redistribution, scheduled repositioning, moisture management, nutritional optimization, and vigilant skin monitoring to prevent further tissue breakdown and to support healing of the existing stage 4 sacral pressure injury.

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)

1. Continue NPWT to sacral pressure injury at continuous suction of 125 mmHg.
2. Change NPWT dressing every 48–72 hours or sooner if seal is compromised.
3. Cleanse wound with normal saline or approved wound cleanser at each dressing change.
4. Apply UrgoTul contact layer to wound bed prior to black foam placement.
5. Protect periwound skin with skin barrier to reduce moisture-associated skin damage.
6. Reposition patient at minimum every 2 hours; avoid prolonged supine positioning.
7. Utilize pressure-redistributing mattress and chair cushion per facility protocol.
8. Offload sacrum when in bed and chair; avoid direct pressure over wound site.
9. Minimize friction and shear during transfers and repositioning; use draw sheets or mechanical assistance as needed.
10. Assess skin integrity head-to-toe each shift with attention to bony prominences.
11. Monitor wound for signs of infection including increased drainage, odor, erythema, or pain.
12. Collaborate with dietitian to optimize protein and caloric intake to support wound healing.

13. Encourage family involvement in pressure injury prevention strategies as appropriate.

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

This encounter reinforced the importance of thorough wound assessment, accurate measurement, and consistent application of NPWT principles. Family involvement was beneficial for patient positioning and comfort. If revisiting this encounter, earlier coordination with nursing staff may have further optimized positioning and reduced procedure time. Continued monitoring of nutrition and mobility will be essential to support wound healing in the context of cardiac comorbidities and prolonged hospitalization.

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?

To further develop clinical decision-making skills related to troubleshooting pouching system failures and to increase independence in developing and adjusting ostomy plans of care.

Was it met? Why or why not?

Yes. The goal was met through hands-on involvement with multiple complex ostomy and fistula management scenarios. Opportunities to assess pouch function, adjust systems for high output, and evaluate when interventions such as intubation were not indicated strengthened clinical judgment and confidence.

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

To continue refining independent development of ostomy and wound plans of care, with a focus on proactive prevention of pouching complications and earlier identification of barriers to patient education.

For instructor use only. Do not 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	✔	

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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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