Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ____Nian Wan_____ Day/Date: __6/01/09/2026_____

Number of Clinical Hours Today: __9__ Number of patients seen__**4**__

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

Preceptor: ___Elizabeth "Betsy" Kulling, BSN, RN_____

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.

#1 – 38-year-old female with Gardner Syndrome and underwent ileostomy with approximately 40 cm of intestine left. Patient was admitted to the ICU and needed pouch change.
#2 – 47-year-old patient in ICU required ileostomy pouch change.
#3 – 47-year-old male with aortic dissection, STEMI, CAD, CKD, and colonic perforation secondary to peritonitis status post total abdominal colectomy and partial colectomy with loop end ileostomy. Patient seen for NPWT changes, wound care, and pouch changes. Plastic surgery came to bedside to debride multiple wounds.
#4 – 66 year-old patient with ileostomy secondary to diverticulitis. Changed patient pouch and provided

Meeting with transplant surgery to discuss skin only closure and concerns regarding:
Mucocutaneous junction – agreement flange be larger so transplant team able to inspect.
Convex pouch to prevent leakage okay to use. Two pieces better than one piece for inspection.
Sterile pouches not needed in the future. Only time appropriate is when in the OR.
Rods not always needed to be removed.
Use clinical judgment whether to use or not use convex or flat flange.
Photos not needed daily while patient admitted as transplant team sees patient daily and takes photos.
Meeting used to discuss

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,

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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	1
Activity	1
Mobility	1
Nutrition	3
Friction/Shear	1
Total	8

Chief complaint: Dressing change, negative pressure wound dressing change, and ileostomy pouch change.

HPI: 47-year-old patient with history of aortic dissection status post ascending aorta replacement, STEMI status post stent to the RCA, chronic kidney disease, colonic perforation with secondary peritonitis and status post total abdominal colectomy and partial colectomy with loop end ileostomy. Patient also has wounds in the sacral, right ischial, right shoulder, left chest to axilla.

Right shoulder wound:
The wound measured 11 cm x 15 cm x 1.5 cm undermining from 8 o'clock to 4 o'clock. Wound bed consisted of 50% granulation tissue, 40% slough, and 10% exposed bone. Wound edges open. Drainage consisted of minimal serosanguinous fluid. Wound had no odor. Patient reported pain with pressure.

Skin was washed with warm water. 3M Cavilon no sting skin prep applied. A transparent dressing framed the periwound. Wound bed irrigated with normal saline, black foam cut to fit wound bed, and bridge to the right shoulder. Negative pressure applied at -100 mmHg continuous pressure. Adequate suction achieved with no leaks detected and no foam in contact with skin.

Left chest/axilla
The wound measured 12.5 cm x 9 cm x n2.5 cm undermining from 9 o'clock to 11 o'clock with 3.2 cm undermining. Skin washed with warm water and 3M Cavilon no sting skin prep applied; Brava barrier sheet picture framed to periwound skin. Wound bed irrigated with normal saline. Honeycomb pattern foam pieces cut to fit into the wound bed and then the solid foam placed in the wound bed. Negative pressure applied at -125 mmHg, low continuous pressure with adequate suction. Vashe 22 mL every 2 hours for 10 minute soak time.

The left upper back wound had moderate amount of bleeding. No NPWT applied. Plan to return tomorrow to apply NPWT to the wound. Bilateral ischial and coccyx wound were cleaned and packed with saline soaked Kerlix and covered with 5x9 abdominal pad and secured with paper tape.

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Loop ileostomy pouch change. Diameter of stoma is 1 ¼" and located in RUQ. Stoma budded, red and moist. Mucocutaneus joint intact. Peristomal skin clear and intact; peristomal contour rounded

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)

For NPWT [left chest/axilla and right shoulder], if alarm sounds, investigate area of leak. If unable to find leak, remove the negative pressure dressing and apply wet to dry dressing. Irrigate kerlix with normal saline and apply with Kerlix. Cover with abd pads and tape with paper tape. Contact wound ostomy service so can replace NPWT.

Change the NPWT in left chest/axilla and right shoulder three times per week, Monday, Wednesday, and Friday per guidelines. Once again, measure the wound for any difference in closure. Coordinate with plastic surgery for debridement while performing NPWT dressing change on Monday, Wednesday, and Friday.

For non NPWT, clean surrounding periwound. Perform wet to dry dressing change. Wet Kerlix and place in wound. Apply dry abd pad to cover over the wound bed and Kerlix, and tape securely over abd pads.

For ileostomy: Wash surrounding skin with water and dry. Use ConvaTec Sensi Care No Sting Adhesive Remover wipes to gently release worn pouch. Apply ConvaTec Stomahesive powder to denuded skin as needed. Apply 3M Cavilon no sting skin prep and transparent dressing pictured framed to periwound skin.

Patient Braden score is 8, which places him at high risk for pressure injury. Ensure that bony prominences are not in direct contact with hard surfaces, such as the bed. Reposition with pillows. Ensure that the NWPT foam is not in direct contact to skin but over drape. Ensure that the patient is not lying over the pump and hose, especially the NPWT dressing on the shoulder. Check skin daily for potential non-blanching, discolored skin. Continue with tube feeds as directed in order to provide nutritional needs for wound healing.

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

There were a total of six wounds that needed cleaning as well as an ileostomy change. I wonder if it would have been possible to work with plastic surgery to ask to break up the debridement – do some for today and then for tomorrow. It became very stressful – even for the nurses.

I would have been a lot more "relaxed". One of the WOC nurses was singing, dancing, and laughing. The patient, despite having a trach, started to sing, too! In fact, this had him and his wife laughing. This helped him to feel connected with people versus a patient in the ICU, which can be stressful. When I work at my job and am doing wound care that takes a long time, I know talking about movies, music, or something that the

patient is interested in helps humanize what is a potentially cold, sterile situation. I know it will take a while to have that ability to be comfortable in one's skin while performing complex wound care – but even holding a hand or smiling would help bridge a connection. In the end, the patient smiled at me and mouthed, "thank you." I thanked him and waved – but I felt stiff.

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 finally be "independent" and to start to do some patients who are straightforward with little

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

Start to "take charge." Review the patient notes and start discussing plan of care.

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 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	✓	

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Reviewed by: _____ Date: _____

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