Cleveland Clinic

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

**Daily Journal Entry with Chart Note & Plan of Care**

Student Name: Amanda Peters, RN Day/Date :1/30/26

Number of Clinical Hours Today: 10 Number of patients seen 8

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

Preceptor: Pai-Yun Krug, RN, CWOCN

Clinical Focus: Wound __ Ostomy ____ Continence X

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 8 patients today with Pai-Yun during clinical. The first patient I saw was an interesting case about a patient who uses a pessary for a stage 3 prolapse in which my journal will be about. Next, we saw a patient in the ICU for a follow up with tube irritant dermatitis related to drainage around the tube. The patient's wife has been taking care of him for 8 years, and he had had 4 tube exchanges. The patient's wife was educated on treatment of the skin damage around the tube, and therapies that could be performed such as hydrophilic wound dressing cream or pouching the area to contain the drainage. Ultimately, the patient's wife declined either of these treatments. The patient's wife wanted Cavilon liquid skin protectant, split gauze, and ABD. It was really hard as this was Pai-Yun's second attempt at educating the patient on importance of treating the open areas of the peri-tube skin. We then saw a patient who had an infected stage 3 pressure injury to the left heel that was 0.2 cm of depth. The podiatrist is planning to do a debridement to this site. It was decided to use 4x4 Mepilex Ag for the patient for small amounts of drainage. Then, we saw a patient who we actually saw a couple weeks ago during clinical with 2 existing ostomies. The patient was experiencing LLQ to his previous nonfunctional colostomy site. The patient also has an ileostomy to the RLQ. The patient has multiple comorbidities and the wife is debating on going home with hospice with this patient. We educated the patient's wife on how to change the ostomy appliance to the RLQ, as the patient was previously the one who changed his pouch. We were consulted for a patient who is known to Pai-Yun with a full thickness seat-belt sign wound to the RLQ that is healing. We used a Hydrofera Ready dressing. He also has an existing colostomy; however, he takes care of the ostomy himself and did not require any assistance with the pouching system nor supplies as he brought his own. We then saw a patient with venous stasis dermatitis that has never worn compression before. The patient came in for back pain and also was experiencing obesity hypoventilation syndrome. He refused an ABI as he could not lay flat for extended periods of time, and spent most his time in a chair. The venous wounds were dressed with calcium alginate dressings and ABD due to high amounts of serous drainage. Tubi grip size G was applied. His coccyx and buttock were checked for pressure injuries, however no wounds were observed. We then saw a patient with a history of a right BKA

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and left 3rd amputation site wound. However, this wound was old on the avatar on EPIC charting system and healed. The wound was left open to air. Lastly, we saw a patient with an arterial ulcer to the 4th toe. The woud was down to the bone and purulent drainage was observed. The patient is going to have vascular and podiatry intervention, Aquacel Ag hydrofiber was used to fluff into the site and secured with stretch net size 1.
Pai-Yun and I discussed different types of pessaries used in prolapses, urge incontinence, and stress incontinence. We also discussed the process of teaching a patient with clean intermittent catheterization as she does not get much opportunity to teach this in this hospital.
Types of wounds: stage 3 pressure injury heel, left 3rd toe amputation, lower extremity venous disease, tube site MASD
Types of patients: acute on chronic mixed UI with acute fecal incontinence (functional), colostomy and ileostomy 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 | 3 |
| Moisture | 2 |
| Activity | 1 |
| Mobility | 2 |
| Nutrition | 3 |
| Friction/Shear | 1 |
| Total | 12 |

Medications: Lipitor 20 mg PO every night, Buspar 5 mg 2 times daily, Rocephin 1G IV every 24 hours, ferrous sulfate 325 mg 1 tab PO daily, Neurontin 300 mg PO 3 times daily, Humolog sliding scale every 6 hours scheduled, metoprolol succinate 12.5 mg PO every 24 hours, LR @ 100ml/hr IV

Labs
WBC 7.6
HGB 8.6 (6.6 upon admission)
PLT 810
SODIUM 140
POTASSIUM 4.1

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CREATININE 4.1
BUN 8
GLUCOSE 132
HGB A1C not available

Patient alert, oriented, resting in bed, no s/s distress, call light and personal items within reach. The patient has a history of a grade 3 uterine prolapse. She reports pessary use for 10 years with improvement of mixed UI symptoms including urgency and urinary leakage when coughing and laughing. In November 2025, she had a retained pessary that was placed over 2 years ago that was removed by inpatient gynecology. The patient was instructed to follow up with urogynecology. However, the patient went to a skilled nursing facility and has not been able to follow up. The patient was readmitted for symptomatic anemia, in which blood was found in her bladder and gross hematuria. Her cat scan per EMR review showed circumferential bladder wall thickening. She also presented with left hydronephrosis due to reflux per EMR review. She was ordered a Foley catheter with continuous bladder irrigation per the urologist. She continued to need irrigation over the past 2 days during admission due to clots. The Urologist was called to bedside this AM and he had difficulty irrigating the CBI catheter after an obstruction occurred. The patient will be needing a cystoscopy today per EMR review. The wound team was consulted for dermatologic changes to the buttocks. She reports she had the retained pessary for over 2 years due to her previous provider stopping service that provided her follow up for pessary exchanges. She is currently non-ambulatory and dependent of ADLs.
-Incontinence associated dermatitis (MASD) to the buttock, gluteal cleft, sacrum, lower back, and upper posterior thighs with pink, red, blanchable, moist open areas. Causes possibly from diaper use within the previous SNF (heat, sweat, trapped moisture), urinary and stool incontinence. The peri-wound has blanchable erythema and is dry. There is satellite lesions present on the upper back; however, the patient has already been prescribed Diflucan per medication review and hospitalist note. The patient reports she was previously continent with pessary use prior to hospital admission in November 2025, but since pessary has been removed and the patient's mobility has decreased, she has become incontinent of urine. Patient reports she is still able to tell when she needs to have a bowel movement. The patient has a patent bulbocavernosus reflex. Patient reports she was urinating slightly when she coughed or laughed after pessary removed. She also reports a strong urge to urinate, indicating that the patient has a mixed UI history. There is also a functional component to her incontinence, as she was ambulatory prior to last November and now bed bound. Cleansed entire area with Stryker Sage Essentials pH balanced wipes and allowed to dry. Applied Cavilon advanced wand to skin for protection of external moisture. Then, applied hydrophilic wound dressing cream to affected areas as it adheres to difficult to dress areas and provides a moist healing environment for open areas. Changed the patient's protective under pads underneath patient, as the previous pads were soiled with blood-tinged liquid (urine vs. irrigation solution).
-The patient has a 3-way 18 FR foley catheter that was indicated for CBI and ordered per the urologist. The foley is secured with a STATLOCK. The patient will need continuation of Foley catheter care including use of BD Surestep Foley care wipes twice a day per protocol.
-Intertriginous dermatitis to bilateral breast folds: Suspect this is from trapped heat and seat to the area. There is erythema to bilateral breast folds. The peri-wound is moist but intact. Cleansed area with Stryker Sage Essentials pH balanced wipes and allowed to dry. Applied Medline skin absorbent dry sheets to areas for absorption of moisture.
-The skin on the patient's bilateral heels is intact with no erythema or open wounds. Applied Optiview transparent silicone heel dressings to bilateral heels for insulation and protection. Then, applied Medline

Heelmedix boots for pressure offloading.
-No other wounds noted at this time
-PT consult will be needed after CBI is discontinued as patient was previously ambulatory prior to November 2025 and is now bed-bound
-A low air loss mattress (Dolphin) was initiated by primary nursing staff for pressure redistribution and microclimate control
-Turned patient to left side with 30-degree side lying blue wedge; patient will need to continue q2hr turns and repositioning for pressure injury prevention.
-No use of briefs, as patient is bed-bound, and briefs can trap moisture and heat.

-All questions answered. Pt d/c plan is pending at this time. Pt may be discharging to a different SNF.
-Patient will need to follow up as instructed by inpatient gynecologist for outpatient urogynecologist follow up for evaluation/continuation of Cooper Gellhorn Pessary Ring.

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)**

**Pressure injury prevention**
*Turn and reposition patient Q2 hours and reposition with 30-degree blue wedge
*Reposition patient Q30 minutes while in chair with chair waffle pad as tolerated
*Elevate patient's heels with multi-PODUS boots while patient is in bed for pressure redistribution
*Assess patient every 2 hours with turns for incontinence

**-Shear and friction prevention**
*Turn and reposition patient Q2 hours and reposition with 30-degree blue wedge
*Move patient with lift sheet as needed for repositioning in the bed, avoid dragging the patient's skin along the bed
*Elevate the head of the bed to 30 degrees or less as tolerated to prevent sliding down in the bed

**-Bilateral breast intertriginous dermatitis:**
*Cleanse area with pH balanced wipes and pat dry
*Apply Medline skin absorbent dry sheets to areas for absorption of excess moisture
*Perform every 12 hours or as needed if soiled

**-Prompt incontinence care**
*Assess patient's protective under-pads with turning schedule for soiling

*Change protective under-pads on patient's bed every 12 hours or more frequently if soiled

**Incontinence associated dermatitis to buttocks, gluteal cleft, posterior thighs, and lower back related to acute urinary, stool incontinence, and excess blood exposure**
*Cleanse denuded areas with pH balanced wipes and pat dry
*Apply hydrophilic wound dressing cream to open and denuded areas as the cream will adhere to wet skin, provide a moist healing environment and keeps the wound protected from external moisture
*Perform every 12 hours or as needed if soiled or after exposure to incontinence
*Cleanse patient **gently** for incontinence care as needed with pH balanced wipes by patting, do not rub
*Cleanse with pH balance wipe and reapply triad hydrophilic wound dressing cream if incontinence occurs
*Cleanse Triad cream down to bare skin every 5 days and reapply per instructions

-Mobility training per recommendations of physical therapist
-Waffle cushion use while patient is up to chair
-Q30 minute repositioning while patient is up to chair for pressure injury prevention

**Foley Catheter care**
-Every 12 hours or PRN if catheter is soiled, cleanse the Foley catheter, labia, groin with BD Surestep Post Insertion Foley care wipes
-Ensure urinary drainage bag is below bladder and off of floor at all times
-Empty urinary drainage bag if 400 ML of urine resides in bag and avoid splashing when emptying
-Ensure tubing is free of kinks and dependent loops to maintain catheter urinary flow
-Maintain catheter securement device and replace every 7 days or PRN if soiled
-Removal by instruction of urologist when applicable

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

I think moisture management of the patient's intertriginous dermatitis was acted on appropriate, as there were not quite open wounds to the bilateral breast folds. However, there was evidence of trapped moisture and heat due to the erythema bilaterally. The nurses were already using pH balanced wipes to cleanse the patient. It is suspected the patient has skin fold care issues at her outlying facility as she reported the area was burning upon the wound team coming into the room and reported it has been going on for some time. The patient will need to continue skin fold care at her outlying facility as this is expected to be an ongoing issue for her.
-Regarding the denuded areas to her backside, the patient reports she wore a brief during her SNF stay. This

is not acceptable as it trapped the stool and urine against her skin and possibly caused her denudement. The patient will need a toileting schedule and a strict no use of briefs with the use of Triad wound dressing cream and protective under pads to allow the wounds the heal. Once physical therapy is able to see the patient, a mobility plan can be created and the toileting plan can follow.
The Dolphin low air loss mattress will assist with pressure redistribution and microclimate control as the patient is currently having moisture issues. The patient did not actively have a pressure injury, but since the patient is currently bedbound with a Braden score of 12, she is at a higher risk. Initiation of Q2 hour turns will also contribute to pressure injury prevention, along with prompt incontinence care.
Physical therapy can also assist nursing in determining the best way to get the patient more mobile. This may need to be addressed when acute bleeding issues of the bladder subside. In my plan of care, I added q2 turning and repositioning with a 30-degree blue wedge while the patient is in bed. The patient is able to move more easily on the Dolphin mattress rather than a regular hospital mattress.
-The patient is at a high risk for shear and friction injuries. The patient can be moved in bed via lift sheets to avoid dragging the skin directly against the bed. Regarding incontinence care, the patient will need to be cleansed gently with pH balanced wipes to avoid friction injuries, as with urinary incontinence, the pH of the skin can be changed and moist, making the skin more susceptible to open areas if a brief is used after the Foley is removed. Prompt incontinence care will be key as well for prevention of skin damage, as mixture of stool and urine together may reactivate stool enzymes and begin to denude skin. The patient was reminded and needs to be continued to be reminded to let nursing staff know if she has the urge to defecate to be able to use a bed pan. Hopefully, with physical therapy assistance, the patient will eventually be able to get up to a BSC for toileting schedule. At time of wound assessment, the patient was about to go for a cystoscopy; it is not an appropriate time to educate on a toileting schedule due to acute Foley use.
-Catheter care was addressed, as the patient has a 3-way Foley for CBI as ordered by the urologist. Once the urologist clears for removal, the nurses should follow the nursing removal protocol.

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?**
I would have liked to educate a patient, with chronic incontinent issues that has not gotten a chance or knew about toileting plans and incontinence conservative management if a patient is available or investigate further into patient's incontinence issues. At this time, no patients were available of this type, as many patients were acutely ill and not ready for this type of education at this time.

**What is/are your learning goal(s) for tomorrow?** **(Share learning goal with preceptor)**
I would like to discuss a bladder diary initiation with a patient, or plan a toileting schedule for a patient with cognitive or functional issues that contribute to incontinence.

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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 | ✓ | |
| • 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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