Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: ____Scott Strazzella_____ Day/Date: _02/06/2026_____

Number of Clinical Hours Today: __8__ Number of patients seen__**4**__

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

Preceptor: ___Denise Santos_____

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 started with seeing a patient with chronic venous ulcers to his bilateral lower extremities, with wounds that had small amount of serous drainage. The wounds on the bilateral lower extremities were cleansed with VASHE antimicrobial solution, application of Xeroform sheets over the wounds, covered with ABD pads, and wrapped with Kerlix gauze roll. The next patient was an individual with a pressure injury to her sacrum. The pressure injury wound bed had a small amount of yellow slough in the wound bed and small amount of serous drainage. The wound edges were poorly defined, the wound was cleansed with VASHE antimicrobial solution, Santyl was applied to the wound bed over the yellow slough covered by a saline wet to moist gauze. The wound was covered with an ABD pad, secured with paper tape. The third patient was a female with a full thickness wound to her right lateral thigh requiring a wound vac. The last patient was a gentleman requiring scheduled wound vac dressing changes to his left foot post left trans metatarsal amputation. The wound vac dressing changes are being completed by the WOC team every Monday/Wednesday/Friday. After documentation was completed, my preceptor and I performed inventory of our wound care supplies and returned patient phone calls from the Ostomy clinic.

Types of Patients: Venous ulcers, pressure injury, Left foot wound Vac, Right thigh wound vac

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

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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	2
Mobility	3
Nutrition	3
Friction/Shear	2
Total	16

The patient is a 69-year-old female with a past medical history of PAD, Hypothyroidism, Multiple Sclerosis, COPD, and fibromyalgia with a past surgical history to her right lateral thigh requiring recent several debridement procedures to the right thigh. The patient presented to the emergency room with concerns of a right lateral thigh wound infection which required a right lateral thigh wound vac placement. WOC saw the patient in her room, evaluated the wound to her right lateral thigh to ensure appropriate for a wound vac. The WOC RN requested the patient's bedside nurse to give the patient any ordered pain medication prior to removing the old wound vac dressing. The WOC team removed the old dressing which was packed with moist Normal Saline gauze. The wound was cleansed with 0.9% Normal Saline. The edges of the wound were approximated; no drainage or odor was noted. Erythema was present along the edges of the wound bed. Wound measured 3.5cm x 7.8cm x 2.1cm. Cavilon no-sting barrier film was applied around the periwound prior to draping around the primary wound. One piece of black Granufoam was placed in the wound to fill the wound bed. Additional draping was placed to seal the wound; Trac pad placed over the black Granufoam with suction at -125mmHg. Patient tolerated dressing change. WOC informed bedside RN of the completion of wound vac dressing change and discussed with bedside RN the importance of elevating patient's right leg and turning patient every 2 hours to prevent pressure injuries. WOC discussed with bedside RN and ordered low air loss mattress. WOC reviewed diet and intake to ensure adequate intake of protein. Discussed with patient preference of Ensure protein shakes, asked nutrition team to order protein shakes to patient diet. Reviewed patient chart to examine if patient has PT ordered.
WOC documented if device was leaking or dressing integrity was compromised, unit RN should assess dressing and device prior to paging WOC team. If NPWT remains off for more than 2 hours, a rescue dressing of saline moistened gauze should be applied to wound bed, covered with ABD pad, wrapped with Kerlix and secured by paper tape. Unit RN should reference WOC website on portal page for troubleshooting NPWT. Any new deterioration prior to WOC follow up, contact the attending service. WOC team is available Mon-Fri from 8:00am-4:30pm.

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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)

- Determine if patient has pain medication requirements prior to dressing change and ask bedside RN to administer as ordered at least 30 minutes prior to dressing change as per physician order
- Gather wound vac dressing supplies including: wound vac black Granufoam kit, Normal Saline, dressing change pad, scissors, new wound vac canister (if needed), 4x4 gauze pads, and Cavilon skin barrier.
- Wash hands thoroughly with soap & water prior to any wound care.
- Introduce yourself as WOC nurse and the purpose of your visit.
- Ensure low air loss support surface/mattress is being used for patients. If not, place order for low air loss mattress.
- Raise patient bed to comfortable working position for dressing change.
- Remove old dressing.
- Cleanse wound with 0.9% Normal Saline
- Assess wound for any deterioration or additional skin breakdown
- Take photos of wounds for patient chart
- Apply Cavilon 3M skin barrier film around edges of the wound, let dry
- Frame around wound using wound vac drape to protect skin
- Cut to fit black Granufoam to wound bed
- Place wound vac drape over black Granufoam, covering entire wound to create a seal.
- Cut a dime size hole in the drape over the black foam and place the wound vac Trac pad
- Replace new canister to the wound vac pump
- Connect wound vac pump canister line to the wound vac Trac pad line
- Turn on wound vac pump
- Ensure lines are unclamped and that line is not pinched
- Ensure pump suction is set at -125mmHg
- Monitor pump is not alarming and black foam dressing is collapsed ensuring adequate suction
- Assess documented offloading is being completed, ensure turning wedge is available in room.
- Review chart for any physical therapy notes or schedule to ensure increase in activity if tolerated.
- Review patient I/O's to ensure adequate food and hydration
- Assess documented protein intake to support wound healing, consult nutrition as needed
- Place referral to outpatient wound care clinic for wound care post discharge
- Discuss with patient and case management the availability for home health care nursing for wound management

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- Dressing to be changed every Mon/Wed/Fri or as needed.
- Contact WOC team via Vocera for any deterioration of existing wounds, the wound vac dressing has a persistent leak, or the wound vac pump is malfunctioning.
- Place 0.9% Normal Saline moist dressing covering the wound bed if NPWT has been off for more than 2 hours.

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

Check with the patient the availability of family to assist in management of her wound with reference to transportation to wound care clinic or assistance in wound dressing changes everyday care at home.

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 was to provide ostomy care. My goal was not met

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

My goal for tomorrow is to provide some type of continence care either with ostomy care or suprapubic catheter exchange

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	✓	

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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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