



R.B. Turnbull, Jr., M.D. School of WOC Nursing

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

Student Name: Alexis Faria Day/Date: January 9, 2025

Number of Clinical Hours Today: 8

Care Setting: Hospital  Ambulatory Care  Home Care  Other

Preceptor: Jennifer Brinkman

Clinical Focus: Wound  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.

On this day, was able to learn about the Wound Vision Scout thermal imaging system used at the facility to assess for potential areas with pressure injuries. Rounded on 5 new consults. Patient with multiple complex wounds who was unable to be seen due to critical change in status and unstable to be turned – per NP on unit. Reviewed and discussed wound images in chart. Multiple patients with coccyx pressure injuries as different stages. Patient with venous ulcers to bilateral lower extremities. Walked through the charting and documentation process for wound patients and the aspects of the flowsheets.

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. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care. The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for..., follow- up visit for..., evaluation and management of..., etc Then, describe the visit. Be sure to include any physical assessment, interactions, and specific products were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

#### Chart note:

78 year old female. Consult received for evaluation of coccyx wound. Patient admitted from outside facility with diagnosis of status epilepticus. Unable to obtain a full wound history due to patient status, patient on critical care unit – intubated and sedated. Past medical history includes stroke, chronic afibb, anticoagulation use, HTN. Unit nursing at bedside for assistance. Nursing reports incontinence of stool, none noted at this time. Foley in place with amber colored urine. Patient coccyx with unstageable pressure injury extending bilaterally to buttocks. Wound presents with brown, black, tan, and yellow dry, adherent tissue to central aspect. Peripheral border of wound with red, yellow, and purple tissue discoloration. Periwound is intact with blanchable erythema. Wound measures 11 cm x 8 cm. Small serosanguinous drainage to underpad. Wound with mild odor. We pressure etiology to be pressure due to location over boney prominence, unable to verify mobility status prior to admission. Wound cleansed and dried. Hydrogel placed on wound bed and covered with Allevyn foam dressing.

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)

Plastic Surgery consult to evaluate for possible debridement

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**Wound dressing:**

- a. Remove old dressing
  - b. Gently cleanse with normal saline and dry
  - c. Use skin barrier to prep periwound skin – let dry
  - d. Apply Hydrogel to wound bed, cover with Allevyn foam dressing
- Change daily and as needed

**Continue prevention interventions including:**

Tru-vue heel offloading boots to bilateral heels while in bed  
 Continue specialty surface usage  
 Use positioning wedges for every 2 hour turn and repositioning

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

Care provided today was thorough and well thought out. Patient was unable to participate due to status, but provider thoroughly reviewed the chart and discussed options with the care team. Provider consulted and spoke with general surgery regarding options for patient and recommendations.

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?**

Goal for today was to continue staging and recommending dressings for wounds. Goal today was met. While assessing patients, preceptor would ask my thoughts before staging or recommending dressings. Preceptor would inform whether she agreed with my proposed treatment and if she didn't, she would thoroughly explain the rationale behind her choices. Most suggestions were consistent with her plan of care.

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

Goals for tomorrow would be to look for more complex patients with multiple wounds to try to find a patient for my complex journal.

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	✓	

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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