



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Jane Frances Nassaka Day/Date: 02/05/2025

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Helen Shubsda

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.

Today, I had the opportunity to see six patients alongside my preceptor. Wound care team was consulted to help distinguish between pressure injuries and skin failures. The patients seen included those with incontinent-associated dermatitis, deep tissue injury, sacral unstageable pressure injury, bilateral lower extremity venous ulcers, and various skin failures. It was an insightful learning experience as we evaluated each wound and discussed treatment options. I also participated in educating staff, patients, and their families about care plans while addressing any questions or concerns. My preceptor helped me understand the differences, especially with skin failure, which was new to me.

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:

This is a 75-year-old female patient who was transferred from an outside hospital for a cardiac work-up. Her past medical history includes acute kidney injury, asthma, A-fib, CHF, and hypertension, with no documented past surgical history. Upon admission, the Wound Care team was consulted to assess her sacral wound and bilateral leg ulcers.

During the assessment, the patient was alert, oriented to person, place, and time, and followed verbal

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commands. Medication and labs reviewed. The sacral area showed signs of incontinence-associated dermatitis, with blanchable erythema and maceration. The patient also had leaking from an external urine collection device. Bilateral leg ulcers were observed, which were partial thickness wounds. The patient reported that these ulcers began as blisters and had been managed by an outpatient wound center. She also mentioned that she typically wears compression stockings but is allergic to the elastic in them. The right leg wound was irregular in shape, with a red and yellow base, peri-wound edema, and yellow-brown (hemosiderin staining). It measured 8 cm in length, 9 cm in width, and 0.1 cm in depth, with moderate sanguineous drainage and no odor. The left leg wound was also irregular, with a red and yellow base, peri-wound edema, and yellow-brown (hemosiderin staining). It measured 2.5 cm in length, 2.3 cm in width, and 0.1 cm in depth, with moderate sanguineous drainage and no odor.

The patient's leg wounds were cleaned with normal saline, and Aquacel was applied followed by an ABD pad, which was secured with a Kerlix roll. The peri-wound areas were treated with skin prep. For the sacral IAD, zinc oxide was applied. The patient complained of mild pain during the assessment and had a Braden score of 16, indicating a moderate risk for pressure injuries. Wound photos and measurements were taken for reference. It was recommended that the patient undergo vascular testing, including a venous duplex, venous insufficiency assessment, and ankle-brachial index (ABI) to evaluate blood perfusion to the extremities. Care instructions were explained to the patient, and she verbalized understanding.

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)

Clean Left and Right Lower Extremities wounds with normal saline.

- Gently pat dry.
- Apply Aquacel dressing.
- Cover with ABD pad.
- Secure with Kerlix.
- Change dressing every two days and as needed for strike-through.

Clean the Sacral Area with soap and water, rinse and pat dry, and apply Desitin to the perianal area, coccyx, and sacrum. Apply twice a day and as needed.

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- Place not more than one breathable pad under the patient. Change promptly when the pad becomes wet or soiled.
- Turn and position the patient every 2 hours to off-load the coccyx/ischium, avoid placing the patient on their back. Use Medline Comfort Glide sheet and turning wedges to off-load pressure points. Use a turning clock and document for continuity of care.
- Apply Tru-View heel protectors to bilateral lower extremities to off-load heels while the patient is in bed.
- Contact the WOC (Wound, Ostomy, and Continence) nurse for questions or concerns.

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

I would recommend vascular testing (venous duplex, venous insufficiency assessment, and ABI), to assess blood flow and identify conditions like peripheral arterial disease or venous insufficiency. These tests are crucial for evaluating vascular health, ensuring proper diagnosis, and guiding treatment decisions. A nutrition consult is also beneficial, as it helps address potential dietary issues that could worsen vascular conditions and supports overall health management.

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 continue managing different kinds of wounds, and use of different products

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

To manage complex wound cases

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	✓	

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• WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
• 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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