



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: 02/07/2025

Number of Clinical Hours Today: 8

Care Setting: Hospital  Ambulatory Care \_\_\_\_\_ Home Care \_\_\_\_\_ Other \_\_\_\_\_

Preceptor: \_\_\_\_\_ Erica Yates \_\_\_\_\_

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, I saw five patients with my preceptor. One patient presented with an unstageable coccyx pressure injury, as well as unstageable pressure injuries on the buttocks, both of which were present upon admission. Additionally, this patient had left and right groin wounds and an abdominal wound, all also present on admission. Another patient had bilateral feet and hands with necrotic tissue, along with a deep tissue injury and incontinence-associated dermatitis.

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 the second visit for a 63-year-old female who is being seen with the admitting diagnosis of hepatic encephalopathy. WCCT was consulted regarding irritant contact dermatitis related to fecal incontinence. The patient was found in a semi-Fowler position, and after introducing ourselves and explaining the reason for our visit, she was agreeable. The patient was alert and oriented to self and place (X2). Her past medical history includes ascites, asthma, post-COVID, epilepsy on Keppra, esophageal varices, hypertension, hyperlipidemia, thrombocytopenia, and type 2 diabetes mellitus. She is a former smoker (who quit in 2009). Her past surgical history includes a colonoscopy in 2021, total abdominal hysterectomy in 2001, and total right hip

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replacement.

Braden score was 14, Medication and lab results reviewed, last set of vitals within normal limit, saturating at 95% on 2 liters of oxygen via nasal canula

Full-thickness wounds were noted on the perineum, bilateral buttocks, and coccyx. These wounds were red, brown, and yellow, with surrounding skin that was moist and had blanchable erythema, along with satellite lesions consistent with a fungal infection. The patient was unable to tell whether she was wet and required a two-person assist for bed mobility. She reported pain at the site of the wound at a level of 5/10, and the nurse noted that Dilaudid had been administered 30 minutes earlier. A deep tissue pressure injury was observed on the left heel, which appeared as a distinct area of purple discoloration with overlying intact skin. The surrounding skin showed blanchable erythema. A Foley catheter was noted, with fecal matter extending up to the patient's vulva.

Wound assessment revealed red, brown, and yellow wounds that were painful, with peri-wound blanchable erythema and moist satellite lesions. There was scant serosanguinous drainage, but no odor. The wound was cleansed with a no-rinse skin cleanser, patted dry, and the catheter site was cleansed. Nystatin powder was applied to the fungal lesions, which was sealed with a no-sting skin barrier then applied Desitin barrier cream. For the left heel, the purple discoloration with peri-wound blanchable erythema measured 0.5 cm in length, 1 cm in width, and was 0 cm deep, with no odor or drainage. A no-sting skin barrier was applied, and the area was left open to air.

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)

- Gently clean after each incontinence episode using soft gauze or wipes with 3M Cavlon no-rinse skin cleanser.
- Pat skin dry, sprinkle Nystatin powder, dust off excess.
- Apply No Sting Skin Barrier, let it air dry.
- Apply a thick layer of Desitin cream twice a day and as needed to keep the area covered at all times.
- Assess patient hourly for incontinence and change promptly when wet or soiled. Use absorptive incontinent bed pads, but avoid using briefs.
- Apply Covatec skin barrier to left heel daily. Elevate heels at all times while in bed. Maintain True-vue heel protectors on bilateral lower extremities to offload heels while in

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bed.

- Maintain turning position system to offload patient's coccyx and ischium every 2 hours.

**Foley Care:**

- Clean with no-rinse cleanser twice a day and as needed.
- Thoroughly clean the patient after each bowel movement to remove any stool in the vulva, which may contribute to UTIs.
- Encourage patient to take at least 2 liters of fluid a day at regular intervals and document intake to prevent dehydration.
- stool in the vulva, which may contribute to UTIs.

**Fluid and Nutrition:**

- Monitor blood glucose per primary team orders and medicate accordingly.
- Consult with a dietitian for appropriate nutrition to optimize wound healing.

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

The care provided appears thorough and well-planned, addressing the patient's incontinence, skin integrity, and nutritional needs. The use of specific products, hourly assessments, and positioning techniques are appropriate.

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 enhance my care plan, and I am still working on refining it with my preceptor's guidance.

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

My learning goal for Monday is to deepen my understanding of urodynamic tests. I aim to build on my existing knowledge, focusing on the procedures, indications, and interpretation of results to enhance my ability to assist with and explain these tests to patients effectively.

CRITICAL ELEMENTS	Completed	Missing
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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	✓	
• 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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