



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Patrick Willis Day/Date: Monday, 4/28/25

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.

Following a morning shared governance meeting between wound and ostomy departments, I saw five wound-focused patients with my preceptor.

Types of patients: pressure injury, laceration, cellulitis, dehiscence, MASD, skin tears

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 beginning with a brief, focused history and history of present illness, including why you are seeing the patient. Then, describe the visit including any physical assessment, interactions, interventions, and evaluations. Complete a Braden Scale assessment if this was an inpatient encounter. Identify any specific products used or recommended for use. Remember, this note reflects all that you *did* at your visit, the plan of care reflects your direction/orders *after* the encounter to be performed in your absence.

Chart note:

Consult requested by MD for opinion on multiple wounds. 62 year old male admitted 4/27/25 from outside hospital with diagnoses of septic shock and necrotizing pancreatitis. Complex prior medical history including HTN, T2DM, COPD on 3L O2 at home, OSA non-compliant with CPAP, suspected OHS, CKD Stage III, CAD, HFrEF (EF 30-35%), chronic lymphedema, and chronic left foot wound. Patient has been hospitalized since a motor vehicle accident on 2/19 requiring CPR, intubation. Medications reviewed. Patient has completed extensive course of antibiotics and received scheduled dose of fentanyl for pain control prior to today's wound assessment.

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Head-to-toe skin assessment was performed, and the following present-on-admission wounds were found: unstageable pressure injury to the coccyx extending over sacrum and bilateral ischium and a Stage 3 pressure injury to the left lateral lower leg. These wounds likely developed during extended hospitalization at previous facility. Recent labs showed WBC 8.38, Hgb 6.6, platelets 103, INR 1.4, Na 134, BUN 45, glucose 257, Ca 8.3.

Patient positioned in right side-lying position for assessment of sacrococcygeal region. Abd pads removed with small serosanguineous drainage. A large unstageable wound measuring 33 x 21 x 0.2 cm is covered in black eschar with hyperpigmented periwound skin. Following cleansing with wound cleanser, hydrogel was applied to the eschar to aid autolytic debridement and covered with clean abd pads. Patient wincing/grimacing throughout care, though not obviously correlated to manipulation of wound.

The Stage 3 pressure injury to the left lower lateral leg was found with abd pad adhered to wound bed. This was loosened with normal saline and removed. The wound measures 16 x 2.2 x 0.3 cm with small serosanguineous drainage and thin soft yellow slough covering. After cleansing with wound cleanser, UrgoTul contact layer applied to facilitate atraumatic dressing changes. Aquacel was applied to promote autolytic debridement of slough, to manage wound drainage, and reduce dressing change frequency due to absorptive capacity. This was covered with abd pad and secured with kerlix gauze roll.

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2
Activity	1
Mobility	2
Nutrition	1
Friction/Shear	1
Total	9

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)

Coccyx extending onto sacrum and bilateral ischium – remove old dressing, cleanse wound with normal saline or wound cleanser and pat dry. Apply hydrogel to the wound and cover with ABD pads. Change at least daily and as needed.

Left lower lateral leg – remove old dressing, cleanse with normal saline or wound cleanser and pat dry. Apply UrgoTul contact layer to the wounds, then apply Aquacel Hydrofiber dressing and cover with ABD pads. Secure dressings with kerlix gauze bandage roll. Change every other day and as needed.

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Maintain Tru-View heel protectors to offload heels while in bed.

Continue skin prevention interventions based on Braden risk assessment score.

Obtain nutrition consult for optimized wound healing.

Monitor blood glucose and treat as indicated.

Re-consult wound care service if further needs arise.

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

I believe the care provided was appropriate and an improvement from the abd pads alone that were being used prior to our visit. The original pads had adhered to the wound bed on the lower leg, so a contact layer was wisely used to prevent further adherence.

The risks and benefits of promoting autolytic debridement of the eschar over the coccyx was discussed. Because the hydrogel was not expected to rapidly work through the eschar, the treatment was implemented to begin slowly softening the non-viable tissue. My concern is opening up a wound which will be exposed to incontinence, thus providing an avenue for additional infection in an already critically ill patient.

Based on current condition and possible skin failure, I would have considered placing foam border dressings over other bony prominences like the elbows preventively.

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 for the day was to familiarize myself with the typical workflow of the WOC nurse. This goal was met today. I was briefly introduced to the team's system of consult categorization that determines which patients are prioritized and seen first. This WOC nurse took photos of every wound and preferred to stop after each patient to enter initial assessment info, billing charges, and any orders into the EMR. Full visit notes were documented at the end of the day once all patients were seen.

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

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My goal tomorrow is to learn more about the consult prioritization system developed by the wound department and how the team divides and organizes the workload among a team of 5 WOC nurses.

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 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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