

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Hannah Smith Day/Date: 6/4/25

Number of Clinical Hours Today: 8

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Colleen Baisden

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 the course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

Fasciotomy: skin barrier, aquacel, abd, gauze
Unstageable on heel: black dry eschar, evolving DTI at 9-11 o clock
Burns bilateral LE: skin barrier, Silvadene, aquacel
Pt with skin CA, bump legs on golf cart, hydrafera blue, silver alginate

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:

Pt is a 67 year old presenting to the inpatient facility with Cardiogenic shock. Pt with a PMH of MI, HTN, and former smoker (pt reports quit 2020). Pt previously assessed for Stage 4 pressure injury to coccyx. Upon assessment on 6/4/25, area to the coccyx with large amount of purulent/serosanguinous drainage and moderate amount of loose slough tissue to the base of the wound. Wound area with 7.2 cm tunneling toward L hip. Dressing changed. Packed lightly with Dakin's-soaked gauze and covered with a

silicon boarding dressing. Pt pleasant throughout process and endorsing low amount of pain, complete relief of pain following dressing change and utilization of wedges to turn patient. Discussion with plastic surgery team indicated for further assessment to possibly perform bedside debridement.

Braden Risk Assessment Tool

Sensory Perception: 2

Moisture: 2

Activity: 2

Mobility: 3

Nutrition: 3

Friction/Shear: 2

Total: 14

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)

Remove old dressing

Cleanse wound with normal saline then dry

Apply skin barrier wand to the peri-wound skin and allow to dry

Moisten kerlix with dakin's and gently pack the wound, **making sure not to over pack the wound, be sure to fill tunneled and undermined areas**

Cover with a foam adhesive

Change BID and as needed

Maintain turning and positioning system to off-load patient's coccyx/ischium every two hours.

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

Pt expressed relief of pain d/t wound being properly dressed and after being positioned off. It was rewarding to provide the patient with this relief.

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

<p>What was your goal for the day? Goal for the day is to have confidence helping to decide a plan of care for a specific patient situation. This goal was met as I helped to decide that aquacel would be best for a patient with a large amount of drainage at fasciotomy site.</p>
<p>What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor) Continue to gain confidence with developing recommendations/WOC care plans</p>

For instructor use only. Do not remove or edit:

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> • Identifies why the patient is being seen 	✓	
<ul style="list-style-type: none"> • Describes the encounter including assessment, interactions, any actions, education provided and responses 	✓	
<ul style="list-style-type: none"> • Completes Braden Scale for inpatient encounter 	✓	
<ul style="list-style-type: none"> • Includes pertinent PMH, HPI, current medications and labs 	✓	
<ul style="list-style-type: none"> • Identifies specific products utilized/recommended for use 	✓	
<ul style="list-style-type: none"> • Identifies overall recommendations/plan 	✓	

Plan of Care Development:		
<ul style="list-style-type: none"> • POC is focused and holistic 	✓	
<ul style="list-style-type: none"> • WOC nursing concerns and medical conditions, co-morbidities are incorporated 	✓	
<ul style="list-style-type: none"> • Braden subscales addressed (if pertinent) 	✓	
<ul style="list-style-type: none"> • Statements direct care of the patient in the absence of the WOC nurse 	✓	
<ul style="list-style-type: none"> • Directives are written as nursing orders 	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none"> • Critical thinking utilized to reflect on patient encounter 	✓	
<ul style="list-style-type: none"> • Identifies alternatives/what would have done differently 	✓	
Learning goal identified	✓	

Reviewed by: _____ Date: _____