



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

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

Student Name: Anna Saylor, RN Day/Date: 8/12/25

Number of Clinical Hours Today: 8 Number of patients seen 5

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, and any additional activities.

Today we saw 5 patients for wound care. The patients were all wound care-focused. Our first patient had severe incontinence-associated dermatitis. They were receiving lactulose and had constant stooling. They also had a GI bleed and did not qualify for a fecal management system. The next patient we consulted for a pressure injury on admission. However, on assessment, their skin was red and blanching. The 3<sup>rd</sup> patient had a neck wound that was hard to assess. It was under a trach holder, and due to the amount of secretions that were dried to him, it was difficult to assess. The fourth patient we saw had a healing stage 3 that was present on admission. The 5<sup>th</sup> patient had an evolving DTI and they are who I wrote my note on.

Types of patients: Evolving DTI, healing stage 3, blanchable redness, partial thickness neck wound, severe IAD

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that was **done** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

#### Chart note:

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Wound care was consulted on 8/12/25 to evaluate a 54-year-old male for a coccyx pressure injury. He was admitted on 8/5/25 from an outside hospital for shock. Patient has a history of bladder cancer, chronic pancreatitis, COPD, decompensated cirrhosis, CHF, ef 50%, HTN, OSA, and pulmonary hypertension. Medications were reviewed. Staff report that the patient has complained frequently of pain in the buttocks area. He is incontinent of stool and currently has a Foley catheter. He is NPO for planned procedure. Patient is currently in the ICU and is receiving CVVHD and is on Levophed for blood pressure support. He is agreeable to assessment. With the bedside nurse's assistance, the patient was safely turned on his side. Allevyn foam was removed from the coccyx area and reveals an evolving DTI. The wound is opened, and there is devitalized tissue surrounding the opened area. This area was included in the measurement of the wound. Area was cleansed with normal saline and patted dry. Area measures 10cm in length x 6.5cm in width x 0.1cm in depth. Wound bed is red with minimal sero-sang drainage. Periwound is maroon/black with devitalized tissue. Allevyn foam dressing discontinued and new dressing orderd of UrgoTul contact layer covered by and abd pad with no tape. Educated patient that new dressing should absorb any drainage and prevent peeling off of an old dressing. Patient denied pain and tolerated treatment well. Patient was safely returned to a sidelying position. Patient was educated on the importance of turning every two hours and was in agreement.

**Braden Risk Assessment Tool**

Sensory Perception	3
Moisture	2
Activity	1
Mobility	1
Nutrition	2
Friction/Shear	1
Total	10

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)**

1. Cleanse coccyx with normal saline and pat dry. Apply urgōTul contact layer and cover with abd pad. Do not tape. Change daily and as needed for soiling.

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2. Patient to remain on LAL mattress
3. Continue with tru-vue heel protectors to bilateral heels to offload pressure while in bed.
4. Turn and reposition every two hours

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

I thought the care was appropriate. My other recommendation for a dressing would have been a barrier cream to the area or a triad ointment. However the cleansing off of ointments may have caused more pain.

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 day one with wound care was to do a wound assessment. This goal was met as I was able to assess the wounds along side my preceptor.

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

For day two of wound care I would like to be more hands on with assessing and measuring wounds.

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**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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