

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Blaine McKinney Day/Date: 9/18/2025Number of Clinical Hours Today: 8 Number of patients seen 9Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Jennifer Postle, BSN, RN, CWOCN, CFCNClinical 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 began with marking a patient prior to a HIPEC surgery. HIPEC, or hyperthermic intraperitoneal chemotherapy, combines tumor debulking or removal with heated chemotherapy instilled directly into the intraperitoneal cavity. We saw another patient with NPWT, this time the patient was post plastic surgery and the NPWT was for an incision that had dehisced. We visited with a patient who had an established colostomy to see if they needed any supplies or support. I was able to observe my preceptor troubleshooting pouch problems over the phone. Unfortunately, the patient lives about 2 hours away so they weren't able to come into the clinic, but we found some wound and ostomy clinics closer to them to hopefully get them some resources.

We saw some wounds that were atypical, so that was interesting to see and create a plan for. One patient had a violaceous lesion to their left lower leg that appeared to be growing over the past few days while they were in the hospital. Dermatology was consulted to do a punch biopsy; I will be interested to see what the biopsy shows. The other patient had chronic wounds as well as sickle cell anemia. This day was very busy, as the department I'm precepting is in the process of setting up a new supply closet, so we attended a meeting and mock closet set up. That was fun to see how a different organization functions, our closet is stocked by our manager's administrative assistant, and we have free reign to organize how we wish. This was a much more structured closet and would be stocked by the supply team. I enjoyed seeing how this process worked!

The patient we saw who had a history of sickle cell and chronic leg wounds has a long history with the wound team. He is frequently seen in the immediate care center but often declines dressing changes. Chart review also indicates a long history of medication and treatment plan non-adherence. Reportedly was started on isoniazid to treat latent TB in order to begin immune suppression medications for the pyoderma gangrenosum, however patient did not complete treatment. Because my preceptor is familiar with the patient, she was going to bring supplies and see if he would be willing to let us change his dressings, otherwise we

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

would leave supplies with him for him to do later. Due to the pain from his sickle cell crisis, he asked if we would change the dressings. Upon even entering the room, the smell from the dressings was pervasive so we were glad to change the dressings for him. I struggle with patients who are non-adherent but also disengaged, because you are not able to understand why they're non-adherent and if there's anything that can be changed to provide a better plan of care. It's hard to help when you don't know where they need help. This patient was also discharged from the hematology pain management service due to positive urine drug screens showing fentanyl use. Home health would be beneficial, but patient may not be eligible due to drug use.

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:**WOC Consult Note:**

B.K. is a 39-year-old male with a past medical history of sickle cell anemia, latent tuberculosis, and chronic lower extremity wounds. Per chart review, these wounds have been present for nearly 5 years and in 2023 were diagnosed as pyoderma gangrenosum. Presented to immediate care center for uncontrolled pain and sickle cell crisis.

He is being seen today as a consult for chronic bilateral lower extremity wounds.

Visited patient in immediate care center, patient agreeable to dressing change, appeared uncomfortable, pain medication given during dressing change for 8/10 pain. Previous dressings with large amount of dry drainage, reports dressings last changed 2 to 3 days prior, adhered to patient's legs. Soaked dressings with sterile water to loosen from skin, mild traumatic removal on right leg despite this. Right lower leg wounds larger than left lower leg wounds, both legs with irregular, full thickness, painful erosions. Wounds with slough and debris, posterior edges of wounds moist while anterior areas extremely dry.

Wounds and periwound cleansed with Anasept, wounds beds gently wiped with Anasept moistened gauze. Previously, patient had been using Hydrofera blue ready foam, but reports it sticks so had been using xeroform. At this time, xeroform gauze cut to fit wound bed and placed over wounds, covered hydrofera blue ready foam and ABDs, secured with kerlix rolled gauze.

Patient provided with supplies, recommend changing every 3 days and as needed for saturation.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	4
Activity	2
Mobility	3
Nutrition	3
Friction/Shear	3
Total	18

At mild risk of pressure injury, recommend frequent repositioning as patient is limited to bed due to pain, consider offloading sacrum with wedges and elevating heels off bed. Limit angle of head of bed unless eating.

Dermatology consult recommended, also recommend social work consult to evaluate need for assistance in obtaining dressings.

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)

Recommend consult to dermatology to evaluate wound, recommend consult to social work/case management to obtain assistance with dressings.

Recommend cleansing both legs with soap and water, then spraying wounds with Anasept. Place xeroform gauze cut to fit over wound bed, cover with hydrofera blue ready foam, ABD, then secure with kerlix gauze roll. Change dressings every 3 days.

Could consider a behavioral health consult as well.

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

For this patient, I wish I had more insight into the reasons behind his non-adherence. Overall though I would simplify this dressing and have him change it more frequently, every other day instead of every 3. I don't like the hydrofera as a secondary dressing, as I was under the impression it should be in contact with the wound bed in order to benefit so this seems like an unnecessary expense for the patient. Both xeroform and dry gauze are relatively inexpensive and can be easier to obtain than other dressings. I would consider washing with soap and water, can add Anasept or other wound cleanser to clean the wound bed especially with the chronicity of these wounds. The xeroform would provide a bacteriostatic, moist environment which would help the wounds stay clean after cleaning especially if the patient is not able to change them often enough. I would use dry gauze or ABD pads as a secondary dressing, and then could consider tubigrip or stockinette, or gauze roll to hold the dressings in place. Tubigrip may provide a bit more use because they could be washed. It would be great to assess the patient's nutritional status, I'm sure the sickle cell anemia makes healing more

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

difficult as well.

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 is to create a wound care plan for a patient with assist from my preceptor. This was met, for the patient with the atypical wound that was increasing in size my preceptor inquired about what I would do for the patient's wound. My recommendation after assessing the wound was a non-adherent dressing, an absorbent secondary dressing, and securing. The patient asked that it be a dressing he was able to maintain at home. Ultimately, chose xeroform gauze, then covered with ABD, all of this was secured with stockinette, recommended changing daily. Patient instructed he could cleanse it with soap and water.

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

Learn more about ostomy prescriptions.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.

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: _____

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day.