



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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Sherrie Powell Day/Date: 09/19/2025

Number of Clinical Hours Today: 8 Number of patients seen 4

Care Setting: Hospital Ambulatory Care Home Care Other

Preceptor: Denise Santos

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's clinical schedule consisted of 4 patients seen in the acute care hospital setting. It consisted of two wound VAC dressing changes and two complex wound assessments with dressing recommendations. The first wound VAC dressing change involved a complex dressing to a patient's lower extremity after traumatic amputation. The periwound had a surgical incision approximated with sutures and staples adjacent to the wound that required multiple types of protective and absorptive dressings to manage moisture and maceration. The second VAC was a simple dressing to the top of a patient's head that required a contact layer to protect an Integra bilaminar matrix graft, approximated with staples. The first wound assessment was of bilateral extremity wounds from a person with peripheral vascular disease. The dressing recommendations consisted of cleansing with a hypochlorous acid solution and applying a contact layer with an absorptive dressing to manage drainage and protect the tissues. The second dressing was for a fungating tumor on a patient's chest. The dressings recommended were to address the odor, drainage, and protect the fragile tissue associated with these types of tumors. The rest of the day was spent evaluating photos of suspected pressure injuries. We focus a lot on differentiating pressure injury from moisture-associated skin damage and friction injury.

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.

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

Chart note:

Braden Risk Assessment Tool

Sensory Perception	4
Moisture	3
Activity	4
Mobility	4
Nutrition	4
Friction/Shear	3
Total	22

39-year-old female being seen and examined at bedside for dressing recommendations for a worsening fungating mass located on the anterior and right lateral torso. Patient with a past medical history of anemia, BRCA2, Cancer of overlapping sites of right breast, ER+ (estrogen receptor positive status, HER2-negative carcinoma of right breast, and secondary and unspecified malignant neoplasm of right axilla and upper limb lymph nodes. The patient was greeted while in the chair, and the WOC role was explained. Patient agreed and was assisted back to bed for evaluation. Old dressing removed to reveal a fungating tumor extending from the left breast across to the right axilla. Tumor colors are red and yellow with small areas of black necrotic tissue. Wound noted to be highly exudative with malodorous purulent drainage. Wound edges are poorly defined and friable; periwound is hyperpigmented with no fluctuance or induration. Wound cleaned gently to attempt to remove old Silvadene cream, which caused moderate bleeding. An absorbent dressing was applied with pressure to stop the bleeding. Bleeding was controlled after approximately 5 minutes. Wound blotted with Vashe-soaked gauze and covered with Vashe-moistened gauze. The entirety of the tumor was covered with ABD pads, and the patient's torso was wrapped with rolled gauze and paper tape to secure the dressing. Wound care orders were reevaluated, and the patient's plan of care was modified to address the odor, drainage, and friable tissue of the wound. WOC recommends cleaning the wound gently with Dakin's soaked gauze, applying Dakin's moistened gauze over the entire wound, covering with ABD pad, wrapping the torso with gauze bandage roll, and securing with paper tape BID.

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.

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WOC Plan of Care (include specific products)

- *Discontinue the use of Silvadene
- *Remove old dressing
- *Soak dressing in normal saline if stuck to the wound, making note of the type, amount, and consistency of exudate
- *Gently pat the wound with Dakin's solution-soaked gauze
- *Assess the periwound for any macerated or denuded skin
- *Wipe periwound with 3M no-sting barrier film and allow to dry completely if any maceration or denuded skin is noted
- *Apply Dakin's moistened gauze to cover the entire wound
- *Apply ABD pads over Dakin's moistened gauze
- *Wrap torso with Kerlix gauze roll
- *Secure the dressing with paper tape
- *Monitor for changes in drainage type and odor
- *Maintain twice a day dressing changes with changes as needed for increased drainage
- *Contact the WOC nurse for any changes in drainage type, odor, or new deterioration noted in the wound

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

The patient's wound care orders used Silvadene once daily over the mass. Patient's plan of care was modified to address the odor, drainage, and friable tissue of the wound. New wound care recommendations discontinued the use of silver sulfadiazine, as this medication would have to be applied at least twice a day and wiped off completely to maintain the bacteriostatic properties of the medication. Wiping this thick cream off would repeatedly cause injury to the friable tissue associated with these types of tumors. Instead, the use of a diluted sodium hypochlorite solution (Dakin's solution) will be used to help control odor by decreasing and controlling the bacterial load, thus preventing infection. What I would have done differently is the cleansing of the wound. I caused the patient to bleed heavily when trying to wipe the Silvadene off. I would have liked to be more mindful of how friable these tumors can be. I would have only dabbed the wound and not caused damage to the skin or pain to the patient.

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?**

The goal for the day was to provide more complicated wound care, and the medical units and patients were chosen for that purpose. The goal was met.

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

I still want an opportunity for urostomy management and teaching.

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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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