

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Carla Edeh Day/Date: 11/21/25Number of Clinical Hours Today: 8 Number of patients seen 3Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Theresa CobbsClinical 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.

Patient with a spinal cord injury admitted for skin breakdown.
Patient with a new RLQ K pouch scheduled for a dressing change
Patient with a history of dysmotility that needed to be marked for surgery.

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:

32-year-old female with a known spinal cord injury that has limited mobility and sensation. She has chronic urinary incontinence from her neurogenic bladder. She was admitted because of a perineal rash and pain. Patient states she has had more frequent urinary incontinence for the past one week. Patient with limited mobility and sensation. Woc nurse was consulted due to significant perineal skin breakdown and extensive moisture. I assessed the perineal area and found that it was bright red completely across the labia, perinium, groin, and inner thighs. Patient rates pain 7/10. There were multiple satellite papules and small erosions. Serous drainage was sitting in the folds of her skin that had a slight odor and her skin was warm to touch. I

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gently cleaned the area with warm warm, mild soap, and patted completely dry. I applied miconazole 2 % antifungal ointment the red, moist, and stellite areas., I applied zinc-oxide barrier cream to protect the surrounding skin. I then placed Curad super absorbent wicking pad and repositioned patient. I advise nursing staff to implement check and change rounds for the patient at least every 2 hours.

Braden Risk Assessment Tool

| | |
|--------------------|----|
| Sensory Perception | 2 |
| Moisture | 4 |
| Activity | 1 |
| Mobility | 2 |
| 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)

Reposition and check peri area every 2 hours.
Clean perineal area after each incontinence episode using warm water and a mild soap, rinse and pat dry thoroughly.
Apply miconazole 2 % antifungal cream to the reddened areas and satellite areas twice daily and after each cleansing.
Apply zinc oxide barrier cream to the intact surrounding skin.
Use breathable wicking incontinence pads.
Document perineal skin assessment each shift.
Notify the provider of worsening signs and symptoms.

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

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I saw how chronic moisture can create an environment for fungal growth. This patient had a clear case of fungal dermatitis.

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 was to have a continence issue patient.

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

Getting all my woc class work completed.

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: | | |

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| | | |
|--|---|--|
| • 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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