

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Terryann Simpson Day/Date: 11/21/2025Number of Clinical Hours Today: 8 Number of patients seen 14Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Jill MichalakClinical 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.

Total of 14 patients seen today, and activities as follows:
pressure injury to the upper back
Diabetic ulcer x 3 – (2 had sharp debridement using curettes blades – wound stalled)
Right BKA pressure ulcer
Herniated colostomy- ostomy belt measurement
Calcaneus laceration- wound check
Left breast mastectomy surgical wound – wound vac assessment
Pilonidal cyst – wound check
Right upper arm skin tear- (hypergranulation – silver nitrate stick)
Venus stasis ulcer
Colostomy change – PMASD (crusting method, retracted stoma, strip paste to fill creases)
Wound Vac change- wound dehiscence after open heart surgery
Unna boot/Coban application

WOC nurses function as consultants and develop plans of care (POC) for other caregivers 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	
Moisture	
Activity	
Mobility	
Nutrition	
Friction/Shear	
Total	

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)

This patient is a 56-year-old Caucasian male who came into the clinic today for a 2-week follow-up on his wound post-hospital discharge. He had a diabetic ulcer on the plantar aspect of the right hallux (currently callus and eschar formation). The patient tried compensating with ambulation to ease pressure off his hallux and ended up with a wound to the lateral aspect of his right foot. He is an uncontrolled type 2 diabetic with an A1C of 15.5 while inpatient 2 weeks ago. He also has callus formation on to left plantar hallux.

At today's visit, the wound on the right lateral foot was debrided using a curette and measured L-2.2 cm, W-0.5 cm, and D-0.5 cm to the muscle. the callus/eschar on the right hallux is now tender. Callus was removed, and a wound is present that measures 1x1cm. Callus to the left hallux was also removed, and no wound was noted in that area. He is currently wearing an offload boot to the right and crutches to assist with offloading as well.

Current treatment is cleansing with vashe, packing with iodoform dressing, and covering with border foam dressing.

Plan is to pack with iodoform soaked in ¼ strength Dakin's, cover with foam border dressings for both wounds, and change daily. Refer to a podiatrist and medication therapy for diabetic management. He is currently homeless and living in his car, so he was given food resources. Follow up in 2 weeks at the clinic

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and continue to offload wounds. He was educated on wound management, infection prevention, and diet to promote wound healing. He verbalized understanding of the education and instructions provided.

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

I believe that this was a great plan, simple to follow and manage for the patient, as well as cost-effective. Dressing change-wise I would not have done anything differently; this patient needs more resources. He recently received insurance because he is originally from Alabama and has moved to Toledo. He is not checking his blood sugar because he does not have supplies. I would set him up with a PCP for general health, give him resources for housing or the homeless shelters locally. He is at an increased risk of severe complications and re-hospitalization based on his current wounds and uncontrolled diabetes. I would also have him follow up within 1 week to assess the progress of his wound and his ability to be compliant with the treatment plan.

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 1 was to learn as much as possible with a variety of experiences. I did meet my goal for this day based on the variety of cases that I observed.

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

My goal for the next visit is to see different debridement techniques, obtain wound culture, as well as a hyperbaric chamber.

For instructor use only. Do not remove or edit:

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		

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• 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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