

**Daily Journal Entry with Chart Note & Plan of Care**Student Name: Amanda Peters Day/Date: Friday, December 26, 2025Number of Clinical Hours Today: 10 Number of patients seen: 8Care Setting: Hospital  Ambulatory Care  Home Care  Other Preceptor: Pai-Yun Krug, CWOCN, RNClinical 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.**

I saw 8 patients today with my preceptor. We spent approximately 1 hour with each patient. While most of the cases we seen today were wound-focused, some also had incontinence issues of either urine or stool. My preceptor was consulted today for dressing recommendation status post-surgical incision and debridement of an infected hematoma to the left upper thigh, and we got to initiate negative pressure wound therapy placement with black foam and white foam for the undermining of the wound. We also had to protect the patient's peri-wound skin with Cavilon advanced skin prep and hydro fiber with silver, as her skin was peeling from the previous swelling. We followed up on one of her previous consultations in the ICU with skin failure to the sacrum. The patient had malnutrition issues, oxygenation issues, and was on a ventilator for over a week. We also saw a patient with a shearing injury to the buttock region. The wound edges were jagged and had partial thickness skin loss. We saw a patient with a suspected aggressive form of melanoma metastasis; the patient had multiple firm, raised nodules and papules the back, chest, underarms, and face. The patient is going to be seen by oncology; he received a biopsy today by general surgery. The lesions were dry with no drainage. We saw a patient with a history of Lichen Sclerosus to the vulva and urinary incontinence; the patient refused any topical recommendations due to previous sensitivity of topical creams. We ensured placement of external urinary device and protective under-pads as she is currently not mobile due to weakness and placed recommendations for daily cleansing/PRN with pH balanced wipes. She will be following up with her oncologist and gynecologist. We saw a patient who had a stroke back in October who came to our hospital present with a stage 3 pressure injury, we cleansed the wound with Anasept and filled the wound base with silver impregnated hydro fiber with silver and secured with a silicone foam border dressing. After each patient was assessed, we ensured to discuss with the bedside nurse the recommendations to promote facilitation of the interventions recommended.

Types of patients: stage 3 pressure injury, left thigh surgical wound with wound vac placement, unstageable pressure injury, shearing injury to buttock, suspected cancer with multiple nodules and papules, skin failure wound to sacrum, head laceration s/p staple repair in ER, vaginal opening wound with incontinence related to

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an autoimmune condition

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:**

**Braden Risk Assessment Tool**

Sensory Perception	3
Moisture	2
Activity	2
Mobility	3
Nutrition	2
Friction/Shear	2
Total	14

Patient alert, oriented, resting in bed, no s/s distress, call light and personal items within reach. He was admitted back in early October for appendicitis and discharged to a rehab facility. He was admitted again late October for evaluation of a wound to his right heel that was deemed a pressure injury. This wound was surgically debrided by podiatry, and the patient was sent to a skilled nursing facility. He returns this month for pain regarding the same wound, and states the wound has worsened. He reports he has been wheelchair bound, and been wearing his heel-offloading boot to the right foot while in bed. He has only been toe-touch weight bearing since October. Wound team was consulted by podiatrist for dressing recommendation while MRI is pending to rule out osteomyelitis. Patient agreeable to wound assessment. Removed pink surfactant dressing and silicone foam border dressing placed by nursing. The patient has chronic unstageable pressure injury to the right heel that is present on arrival; the wound base is covered with 90% yellow adherent slough and 10% granulation tissue with possible delayed healing components: diabetes and vascular component. Vascular surgeon and podiatry have been consulted. The wound measured 2cmX3.5cmX0.4cm. The wound base also had red, pink, moist areas. The peri-wound had dark wound edges from 12-2 o'clock and 7-10 o'clock of the wound base. White maceration was also seen on wound edge from 4-11 o'clock. There were small amounts of tan drainage, however no malodor. The wound had soft wound edges. Cleansed the wound with Anasept wound cleanser and gauze to decrease bacterial load. Applied temporary dressing of cut to fit

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silver impregnated hydro fiber with silver for antimicrobial properties and to absorb drainage and secured with a 6x6 silicone foam border dressing (Mepilex) while obtaining order for collagenase ointment (Santyl) to apply to wound base for enzymatic debridement of slough and nonviable tissue. Patient tolerated dressing change well. Applied PODUS boot per podiatry order.

**Patient also reported 9 episodes of diarrhea** this morning; he is normally continent. Patient has had antibiotic therapy initiated during admission. There was very mild erythema to gluteal cleft but no open areas at this time. The patient was clean during assessment; cleansed the patient with a pH balanced wipe. Applied barrier cream for protection to the peri-anal and buttock skin from moisture breakdown related to stool. Changed the protective under-pad on the patient's bed.

All questions answered and encouraged. Patient may be discharging to ALF after workup; he reported they have a wound specialist there and can assist the patient with daily dressing changes. Current wound dressing recommended by the wound team is temporary pending podiatry and vascular workup and recommendations.

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)

**Right heel unstageable pressure injury present on arrival:** Temporary dressing order until podiatry/vascular recommendations or intervention: Daily, cleanse wound with Anasept wound cleanser and gauze and pat dry to decrease bacterial load. Apply collagenase ointment (Santyl) to wound base for enzymatic debridement. Fill the wound base with cut to fit silver impregnated hydrofiber with silver, secure with 6x6 silicone foam border dressing (Mepilex) for protection of shear and friction to area.

**Buttock incontinence associated dermatitis prevention:** Daily and PRN with incontinence, cleanse area with pH balanced wipes, gently dry, and apply barrier cream to peri-anal and buttock skin for prevention of skin breakdown from incontinence.

-Prompt incontinence care, check patient for incontinence every hour or more frequently as needed

-Heel offloading with multi-podus boots per podiatry recommendation

-Immerse low air loss mattress ordered for microclimate control and for pressure redistribution. Transfer patient to mattress when it arrives.

-q2 hour turn and repositioning with 30-degree blue wedge, or q30 minute repositioning while in chair with chair waffle pad

-Call or reconsult as needed for questions or concerns

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

I think I would have changed the dressing to using an antimicrobial blue classic dressing to fill the wound base instead of the use of collagenase ointment, due to the fact that collagenase ointment can be expensive. In this case, it may only be used as a temporary dressing since podiatry or vascular may surgically intervene with the patient's wound.

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 grasp the concept of a basic wound assessment, and learn how to protect peri-wound skin in various different wound types.

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

To learn see the concept of teaching patient care with a new ostomy if there is a consult available. Otherwise, I will like to be able to perform an ABI on a patient.

**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-	✓	

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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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