

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Wei Xu Day/Date: Day 7, 01/13/2026Number of Clinical Hours Today: 8 Number of patients seen 5Care Setting: Hospital Ambulatory Care Home Care Other Preceptor: Erica Yates, APRN-CNSClinical 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.

Number of patients seen: 5

1. Deep tissue pressure injury (DTPI, acquired), G-tube, Trach tube, urine Foley – Details see chart note and plan of care
2. Medical device related pressure injury – the patient had J-tube placed on 12/24/25, the bumper is still sewn to skin. Stage 2 pressure injury underneath. The surgery team were contacted regarding the suture removal (Sutures usually removed in 2 weeks). Skin cleaned with NS and protected with liquid skin barrier films. Education on tube stabilization and tube care offered.
3. Mucosal membrane pressure injures related to Foley catheter, acquired DTI at Coccyx, POA unstageable at left hip, Above knee amputation (AKA) – the patient admitted for left 4th and 5th toes gangrene and underwent AKA on 1/8/2026. The amputated leg Foley was secured by StatLock to right thigh but a little bit tight. Wound area cleaned then Critic Aid Clear moisture barrier cream applied. DTI at coccyx area – Urgotul + foam dressing. Left hip unstageable PI initially covered with yellow eschar, now fell off, hydrogel with foam dressing. Offload + reposition.
4. Type 3 skin tear at right upper medial thigh, DTI at sacrum s/p debridement, urine Foley, internal fecal system management – the patient in Medicine ICU, consulted for worsening pressure injury at sacrum. UrgoTul + foam dressing, offloading + repositioning.
5. Wound hypergranulation s/p skin graft (donor site) – the patient had skin autograft in October. The donor site left lateral thigh, with hypergranulation nonhealing wound. Hydrofera blue + foam dressing applied. Change every other day.

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

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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:

This is a follow up visit for this 76 y/o male with a deep tissue pressure injure at coccyx area. The patient admitted to neuro ICU due to left side subcortical intracranial hemorrhage. The patient has history of obstructive sleep apnea, heart failure, type 2 diabetes mellitus, hyperlipidemia, hypertension, Parkinson disease on Sinemet, atrial fibrillation on Eliquis. The patient received Eliquis reversal with FEIBA and transferred to main campus for further management.

The wound care was consulted on 01/04/2026 regarding the coccyx area. At this time, an acquired deep tissue pressure injury noted. The wound, 4.5 cm x 6 cm x 0.2 cm, is a partial thickness with red and burgundy wound bed with purple discoloration extending onto the left buttock, blistering noted along the edge of the wound, with scant serosanguineous drainage, no odor.

The patient is not responsive, external ventricular drain in place. Trach sutured in place with oxygen via trach mask. G-tube in place with nutrition infusion. Foley in place with yellow clear urine. Bowel incontinence with formed stool.

Braden Risk Assessment Tool

Sensory Perception	1
Moisture	3
Activity	1
Mobility	1
Nutrition	2
Friction/Shear	1
Total	9

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)

Cleanse the wound and periwound skin with NS, and gently pat dry thoroughly
 Apply UrgoTul contact layer to the wound and cover with an Allevyn foam dressing
 Change every other day and PRN
 Turn and reposition the offload patient’s coccyx every 2 hours
 Keep the IsoTour bump on for low air loss

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

The deep tissue pressure injury is acquired during this encounter. Realizing pressure injury prevention is

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challenging in every hospital. For the wound care for this patient, I would like to apply liquid barrier films to the wound, and apply hydrogel to the open area, then cover with a foam dressing.

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?

Saw patients with pressure injuries. No consults for venous/arterial ulcers today. Discussed compression therapy with preceptor.

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

Since most consults are PIs, I would like to review some interesting wound cases in EPIC.

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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