

Daily Journal Entry with Chart Note & Plan of CareStudent Name: Zhane Ceasor Day/Date: Friday 1/16/26Number of Clinical Hours Today: 8 Number of patients seen 5Care Setting: **Hospital** * Ambulatory Care Home Care Other Preceptor: Aaron Fischer, 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.

This clinical day consisted of me seeing 5 patients in the inpatient setting. The first patient seen was a pouch change/re-eval for his jejunostomy, as he was having increased output. We replaced his current pouch with a high output bag. The second patient was seen for a pouch change, and continued education on his end ileostomy (the patient had questions related to his stoma site directly). The third patient was a follow-up wound vac patient that I had seen earlier in the week for his wound vac related to his ECMO injury. Fourth patient was seen for a leaky pouch of her ileal conduit. She had recently undergone a pelvic exenteration, so we completed pouch changes for both her ileal conduit and end descending colostomy. Our final patient of the day was a wound vac change completed on a patient who also received the wound from a previous ECMO.

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:

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Age/sex: 76 y/o Caucasian male

PMH: Pt. has a PMHx of CHF w/CABG X2, and mechanical AVR (2008), T2DM, OSA, HLD, CKD, morbid obesity, CHB with pacemaker (June 2025), embolic CVA x2, recurrent klebsiella UTI from chronic catheter use

HPI: Hospital course dates to 10/2025. Initially presented to OSH with increased lethargy and edema, despite being on Lasix. TEE performed confirmed the presence of thickened MV, LV-RA fistula, and aortic root abscess suspected to be infective endocarditis

Social hx: Resides at home with family, was wheelchair bound prior to hospitalization.

Patient being seen today 1/16/26 in-patient by stoma team in CICU for NPWT dressing change. Patient sedated upon arrival. He appeared to tolerate the change in dressing well.

Assessment:

Location: left upper inner thigh two wounds

#1: upper area: 2.2cm x 1.7cm x 4cm, tunnel communicates with the lower wound. Wound bed red and moist with edges intact

#2: lower area: 5.9cm x 4cm x 3cm, tunnel communicates with upper open wound. Wound bed 50% pink, and 50% yellow tissue with smooth wound edges

Periwound skin: intact

Drainage: serous, brownish drainage observed in canister

Odor: none

Pain: patient did not communicate but no signs of grimacing, or movements of discomfort observed by RN

Braden Risk Assessment Tool

Sensory Perception	2
Moisture	2
Activity	1
Mobility	2
Nutrition	2
Friction/Shear	1
Total	10

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)

1. Cleanse area with soap and water, pat dry. Apply No sting Liquid skin barrier to surrounding skin
2. Place transparent dressing on surrounding skin
3. Apply black thin spiral cut foam into wound bed, ensure that black foam is tucked at areas of undermining, but do not overfill area

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4. Place suction port to the upper area of peri wound skin as a bridge (two pieces of foam used in total)
5. Apply -125 mmHg low continuous suction
6. If wound vac not suctioning for 2 hours or longer, dressing must be taken down and moist dressing placed by bedside nursing. Dressing that stays in place with no suction is an infection risk
7. Dressing changes to be completed by stoma team every Tuesday & Friday until therapy is complete.

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

Overall, I would say that the care provided was great. When first assessing this wound, I thought that it would be a challenge seeing as how initially it looked like two separate wounds, but once we began measuring, we saw how the upper wound connected to the lower. As my preceptor mentioned to me, when you have these types of wounds it is important to not seal a tunnel opening without filing the tract, and to also not overpack the wound bed with black foam (to prevent risk of abscess or pressure injury).

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?

Being that this was my last clinical day, I had no specific goals in mind. I feel that I have had the opportunity to perform a lot in each clinical rotation thus far, so I had nothing specific that I wanted to focus on for today.

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

Today marked the last day of clinical for me, and as I finished out my rotation, I would say that I have had the opportunity to see/take part in the treatment of a lot of awesome clinical experiences It was nice to be able to take the information covered in the videos and discussion boards and implement them into real practice.

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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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