Cleveland Clinic

R. B. Turnbull Jr. M.D. WOC Nursing Education Program

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____Lydia Agyekum_____ Day/Date: _3/25/25_____

Number of Clinical Hours Today: __8__

Care Setting: Hospital _y___ Ambulatory Care ____ Home Care ____ Other ___

Preceptor: __Jennifer Mullin_____

Clinical Focus: Wound _y___ Ostomy ____ Continence ____

Reflection: Describe your patient encounters & types of patients seen.

My encounters with patients vary greatly today, I had encounters with patients on different units with coormodities, including medical/surgical, oncology, psychiatry, neuro intensive care, with different wound types ranging from diabetic foot, arterial and venous wounds, wound dehiscence, fistula, and most of them were pressure injury which was not hospital acquired mostly staging from 3 and 4. Whiles most accepted to be assessed and evaluated others also declined due to pain. Each encounter was an opportunity to assess, measure and dress wounds under preceptorship. I had the opportunity to educate a patient on the importance of using the boots to prevent pressure injuries.

1. A 60-year-old female on the neurological floor with the history of sudden collapsed, her diagnoses are stroke, hypertension, dementia and occasional seizures, she has a wound on her sacrum, she is alert and responsive, pressure injury with pink and moist wound bed staging 2 with peri wound intact.
2. A.89 old female year on the neuro floor with stroke, delirium and UTI, not responsive and alert, she has an intact area of non-blanchable deep red on the sacrum and both heels, she was assessed and was diagnosed of deep tissue pressure injury. Her management includes offloads boots, allevyn over affected areas.
3. A 50-year-old male with a history of diabetes mellitus, hypertension and deep vein on the medical floor, wound care was requested on account of foot ulcer, he declined care, and confess he is in pain despite all pain medication.
4. An 82-year-old female at the CVCIU with the past history of ERSD, cardiomegaly, peripheral arterial disease, she has wound at her left toe covered with dry necrotic
5. 47-year-old female on surgical floor with multiple surgeries, she has a dehisced wound, with moderate draining, wound bed is sloughing and peri wound macerating.
6. A 38-year-old with the history of bipolar, presenting with wound at the right flank resulting from accident, he refused to be assessed, though wound was not covered on arrival, nurses say he pulls out every dressing.
7. A 55-year-old female with spina bifida, who has bilateral amputation was seen on the medical intensive care on the account of pneumonia, she complains of severe back pain at her incisional site at the spine, upon assessment she has non blanchable red/ maroon intact skin at sacrum and spine.

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8. A woman was seen at the oncology unit with history of cancer of the left parotic gland, depression and growth at the groin, she has refused to come out of bed for weeks, she has wound at her left hip covered with slough, the wound is because of accident on their staircase.

Chart note:

82-year-old female with past medical history of periphery artery disease, hypertension, esophageal reflux disease, deep vein thrombosis, is currently admitted for chronic back pain, bilateral lower extremity rest pain, wound at the left great toe covered with dead tissue. She has been diagnosed with cardiomegaly, peripheral arterial disease. Wound care requested by attending physician on the opinion of gangrenous wound at patient left toe she presented on admission. Patient seen and assessed while in chair at the bedside, having pain in BLE, skin is shiny, red and dry, heels are intact, feet are cold, and pulse is faint on doppler scan particularly on left foot. She is very responsive and interactive, mobile and continent, she says her appetite has not changed and drinks a lot of water. She has a small necrotic wound on the left toe.

Medication; heparin iv infusion 25,000 units in NaCl 0.45% 250mls, hydromorphone 0.4mg, ondansetron 4mg, cap pregabalin 25mg, Eucerin, metoprolol.
Labs; WBC 8.91 RBC 10.9 RBS 110mg potassium 3mEq/L, Calcium 2mEq/L, Sodium 137mEq/L
Allergies; no known allergies.
Social Hx; has stopped smoking for the past 10 years.

Braden Risk Assessment Tool

Sensory Perception	3
Moisture	3
Activity	3
Mobility	3
Nutrition	3
Friction/Shear	3
Total	18

Physical assessment.
LOC; Alert, oriented and responsive, Glasgow coma scale; 15
Vitals; temp 96.1, b/p 160/80mmhg, pulse 112, resp 16, wt. 56kg, Spo2 95%, ABI ;0.7

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Wound assessment
Wound location; left great toe
Site Assessment; Black; necrotic
Shape; round
Peri wound; red, dry
Wound length; 0.5cm

Wound width; 0.5cm
Wound depth; 0
Drainage type; none
Drainage amount; none

WOC Plan of Care (include specific products used)

Wash wound with cleanser with every dressing change.
Apply mesalt to necrotic wound of left great toe
Weave gauze gently between toes on both feet as tolerated by the patient, secure with hospital socks.
No tape to skin
Apply Eucerin to legs as tolerated by patient.
Frequency; daily

Barriers to healing; body habits, comorbid conditions, compliance with care regimen, mobility, and moisture.
Education: increase water intake at least 3l per day, maintain legs in a neutral or dependent position to reduce pain, increase tolerated physical activity like walking.
Pressure injury prevention; heel offloading, low air loss surface, moisture management, redistribution surface, seat cushion and turn schedule.
Follow up, patient has outpatient follow up previously planned

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

The assessment carried out was very thorough and holistic, patient wounds were carefully evaluated and pictures taken for the purpose of optimizing the patients' medical care and allowing a visual aid to their wound evaluation and progress. Wound was cleansed with wound cleanser before measurements, patient and family were involved in the care.

I would have used the same cleanser to clean wound and use hydrocolloid dressing (Douderm) , since the wound is dry and it can help to promote autolytic debridement .

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Goals

What was your goal for the day?
Wound management
Education of patients and family on wound.
I was able to identify wounds, cleansed, measure and dress wounds, I had an opportunity to educate a patient and son on the importance of offloads boots, and on wound healing process.

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

Wound management
Patient and family education

For instructor use only. Do not remove or edit:

CRITICAL ELEMENTS	Completed	Missing
Medical record notes reflect 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	✓	

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• 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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