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: _3/26/25_____

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.

Today with my preceptor was another day of experience, we reviewed and assessed both new and old patients in the hospital, including medical/surgical, emergency unit, psychiatry, intensive care unit, with different wound types ranging from diabetic foot, venous wounds, wound dehiscence, deep tissue pressure injury, and traumatic wound. The protocol for skin assessment on admission is a very good intervention, of which nurses are very adhered to. Each encounter was an opportunity to assess, measure and dress wounds under preceptorship.
We saw a total of 10 patients on different units with different types of wounds, but the highest recorded pressure injury not hospital acquired, my preceptor says is a very good indicator of quality nursing management. We discussed the use of allevyn on the management of pressure injury and friction. Most patients were interactive and glad to have students on the team.

Chart note:

An initial visit to a 72-year-old woman with past medical history of pneumonia, no surgeries. Admitted on the account of home accident. She fell from her stairs and hit her left anterior thigh on a metal and sustained a lacerated wound, bleeding, and in severe pain, she has no fracture injuries and was stable when seen, the wound care was requested to assess wound and develop a management care for it. On arrival the patient is in bed with her son, she is alert, awake and oriented. Prop up in bed with her heels on pillow. From the assessment she has bruises, no sign of DTIP and no pressure injury to her back. Her wound was covered with gauze and soaked with serosanguinous exudate as she refuses suturing of wound, she says she believes it will heal.

Medication; NaCl 0.9% 100mls, hydromorphone o.4mg, tab Tylenol
Labs; RBC 10.4, WBC 9.8, RBS 110mg
Social hx; no alcohol, or has ever smoked
Allergies; peas

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Braden Risk Assessment Tool

Sensory Perception	4
Moisture	4
Activity	4
Mobility	4
Nutrition	4
Friction/Shear	3
Total	23

Physical assessment
LOC: alert, awake, oriented and responsive.
Vitals; temp 96.1, b/p 106/ 53, pulse 109, resp, 18, wt. 72kg, Spo2 98%
She is mobile, active, continent and says her appetite has not changed unless in pain, breathing non labored, few bruises on the left hand which was resting on a pillow with ice.

Wound assessment; full thickness lacerated wound
Wound location; left lateral anterior thigh
Site Assessment; red and bumpy
Peri wound; red, intact
Wound length; 5.3cm
Wound width; 2.5
Wound depth; 1.8cm
Drainage type; serosanguinous
Drainage amount; minimal

WOC Plan of Care (include specific products used)

Wash wound with wound cleanser with every dressing change.
cover wound bed with xeroform as tolerated.
cover with gauze and seal with tapes.
or use allevyn if reacting to tape.
change dressing daily
assess for pain.
Follow up, a week after the initial assessment

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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 included in care.

The care of plan is good, but I would have asked nurses to observe wounds for infection and increase in exudates. And educate patients in the need to increase protein intake to help in wound healing and the possible delay of wound healing, scars and possible infections.as she refuses sutures. And for the dressing I would prefer hydrocolloid to the xeroform because is self-adhesive, and creating moist environment.

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?

Wound management, goal met as I was involved in wound assessment and plan of care.

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

Clinical ends

For instructor use only. Do <u>not</u> 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	✓	

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• 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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