Cleveland Clinic

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

Daily Journal Entry with Chart Note & Plan of Care

Student Name: Brittany Sluiter Day/Date: Thursday/January 8, 2026

Number of Clinical Hours Today: 8 Number of patients seen **5**

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

Preceptor: Ashley Given

Clinical 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.

1. 40-year-old male (hx of Crohn's, total colectomy, end ileostomy for follow-up and discharge education)
2. 55-year-old female (hx of Crohn's, abscess, ileostomy, peri wound and perineal rash for follow up)
3. 55-year-old female (hx of BMT, GVHD, bilateral lower extremity wound consultation)
4. 71-year-old female (hx of AMS, seizure, skin failure/new wound on sacrum wound consultation)
5. 30-year-old female (hx of Crohns, ileostomy, fistula, pyoderma, s/p stent placement)

During this clinical day, I participated in the care of five patients, including three follow-up visits and two new consultations, across inpatient and ICU settings. Two follow-up patients had histories of Crohn's disease with ostomy. The first was a 40-year-old male (day 32 inpatient) status post total colectomy with end ileostomy and hernia, seen for discharge education. He demonstrated appropriate understanding of ostomy care, appliance management, and recognition of potential complications. The second was a 55-year-old female with history of Crohn's disease, abscess, and recent blood transfusion, seen for follow-up regarding appliance fit and peristomal and perineal dermatitis. The peri wound and perineal rash showed significant improvement with nystatin, and the pouching system remained intact.

Two patients were evaluated in the ICU. One was a new consultation for a patient with extensive bilateral lower extremity wounds requiring comprehensive assessment and interdisciplinary collaboration. The second was a 71-year-old female with a history of seizures and altered mental status, recently weaned off norepinephrine, with evidence of skin failure at the sacrum. Due to ongoing incontinence associated with tube feeding and liquid stool, the wound care nurse initiated an order for Triad hydrophilic paste to the wound bed to provide moisture barrier protection and promote healing. Education was provided to both nursing staff and family at the bedside regarding skin protection strategies and ongoing care.

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The final patient was a 30-year-old female with Crohn's disease, an ileostomy, two enterocutaneous fistulas, and pyoderma, status post stent placement the night prior. The pouching system was changed, and Eakin cohesive seals were applied to manage fistula drainage and protect pyoderma. A cut-to-fit pouch was applied using a feathering technique to minimize trauma to the affected skin. The patient reported decreased pain post-procedure but noted poor sleep due to overnight drainage, which was addressed through improved containment and skin protection interventions.

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:

Reason for Consultation/Why Patient Was Seen:

Patient evaluated for bilateral lower extremity skin breakdown and hemorrhagic bullae in the setting of severe thrombocytopenia, immunosuppression, and critical illness.

Focused History & HPI:

55-year-old female with HTLV-1 related adult T-cell leukemia/lymphoma, status post allogenic bone marrow transplant (11/22/2024). Hospital course complicated by severe sepsis with bacteremia, atrial fibrillation with RVR, acute kidney injury requiring CCR/HD, graft-versus-host disease, prolonged steroid exposure, thrombocytopenia, malnutrition, and hypoalbuminemia.

Patient developed bilateral lower extremity petechiae, purpura, and hemorrhagic bullae, some of which have ruptured, prompting WOC consultation for skin integrity management and prevention of further breakdown. Patient was seen by Burns team (who signed off and deferred care to ID, Oncology, and wound care as SJS was ruled out).

Pertinent PMH:

- Adult T-cell leukemia/lymphoma (HTLV-1 related)
- Status post allogenic BMT
- Thrombocytopenia
- GVHD
- Sepsis/bacteremia
- Atrial fibrillation
- AKI on CCRT/HD
- Hypothyroidism

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- Malnutrition

Pertinent Labs

- Spot EEG: no seizure
- CT chest/abd/pelvis: no acute findings
- Blood cultures: positive for Pseudomonas aeruginosa
- Platelets: 8
- Albumin: 1.8

Current Medications/Orders

- Allopurinol, 300 mg, NG tube, daily
- Atovaquone suspension 1500 mg, NG tube, daily
- Carvedilol tablet 12.5 mg, NG tube, every 12 hours as scheduled; hold for SBP less than 100, hold for HR less than 60
- Cefepime 2 g in sodium chloride 0.9% 100 mL IVPB, 2 g, intravenous, at 33.3 mL/hr, administer over 3 hours, every 8 hours for 7 days for bacteremia
- Decadron injection 10 mg, intravenous
- Colace 100 mg, Senokot 17.6 mg combo liquid, NG tube, 2 times daily
- (Held by provider) Duloxetine DR capsule 60 mg
- (Held by provider) Gabapentin capsule 100 mg
- Synthroid tablet 200 mcg, NG tube, every morning
- Micafungin 50 mg in sodium chloride 0.9% IVPB, 50 mg intravenous, at 100 mL/hr, administer over 60 minutes, every 24 hours
- Protonix 40 mg in sodium chloride 0.9% IV syringe, 40 mg, intravenous at 300 mL/hr, administer over 2 minutes every 24 hours
- Romidepsin 26 mg in sodium chloride 0.9% 500 mL chemo IVPB, 26 mg (rounded from 26.04 mg = 14mg/m2 x 1.86 m2 Treatment Plan BSA from recorded weight), intravenous, at 138.8 mL/hr, administer over 4 hours, once, on Thursday 1/8/26 at 1600, for 1 dose
- (Held by provider) Ruxolitinib tablet 5 mg for graft-versus-host disease
- Valacyclovir tablet 500 mg tablet, 500 mg NG tube, 2 times daily, first dose Wed 1/7/2026 at 0900, for 48 doses for mucocutaneous herpes simplex
- Osmolite 1.5kcal/mL continuous tube feed, Goal rate in mL: 60, Until discontinued, 0-60 mL/hr, continuous, Starting on Tue 1/6/26 at 1045, Starting rate (mL/hr): 20, Increase by (mL/hr): 10, Increase every 3 hours
- Free water enteral tube solution 175 mL, NG/OG feeds, every 2 hours
- Insulin regular in 0.9% NaCl (MYXREDLIN) 100 unit/100 mL (1unit/mL) infusion, 0-36 units/hr, intravenous, continuous, starting on Wed 1/7/26 at 1645
- Nothing per rectum
- Adult NPO diet NPO except: Sips of clear liquids
- Neutropenic precautions
- Wound care: Apply aquacel silver to lower extremity wounds, change daily
- Bladder scan, every 6 hours, perform bladder scan and/or in- and -out catheterization for urinary retention or incomplete bladder emptying
- Continuous pulse oximetry

- Daily weights
- Consults to Occupational Therapy, Oncology Speech Language Pathology, Oncology Modified Barium Swallow, Adult Bone Marrow Transplant, Cardiovascular Disease, Care Management, Critical Care Medicine, Hospitalist
- Inpatient Specialty Bed (RENTAL) Rental Bed Type: Standard Vertical Therapy Bed (500 lb cap) Hright: 165 cm Weight: 79 kg

Physical Examination/Wound Assessment

-Location:

Bilateral lower extremities, primarily anterior/posterior and lateral lower legs

-Findings:

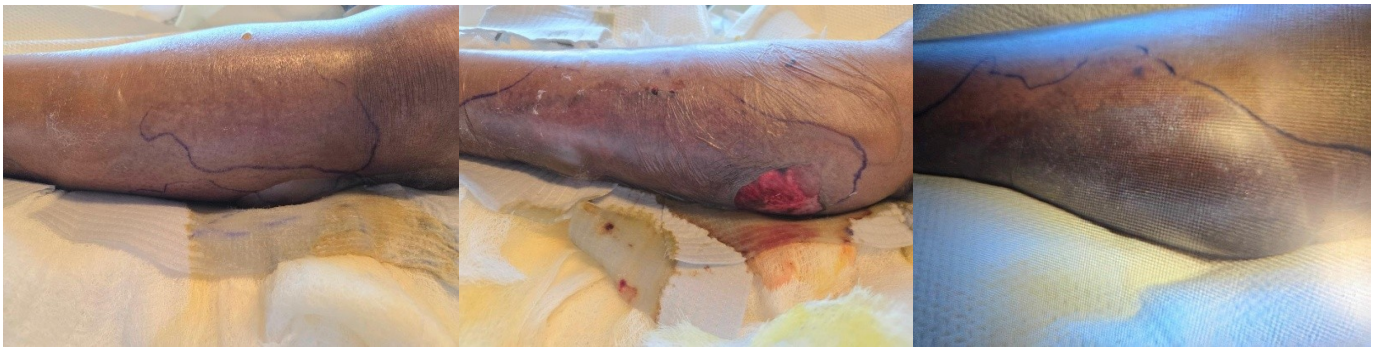
Diffuse ecchymosis and violaceous discoloration consistent with thrombocytopenia
Multiple hemorrhagic bullae, both intact and ruptured (very fragile)
One partial-thickness open area with red, moist wound
Peri wound skin thin, fragile, shiny, and edematous
Drainage serosanguineous
No overt purulence or odor noted at time of assessment

-Assessment:

Skin breakdown is multifaceted, related to thrombocytopenia, immunosuppression, malnutrition, edema, and mechanical shear

Patient is alert to verbal stimuli, oriented to person only, and responds to commands, she can state her name and birthday only, she nods when she is asked questions, and states “No, stop,” with facial grimacing and moaning noted when care is being provided. Patient is on on 2 L of oxygen via nasal cannula, dobhoff in left nare noted, mucus membranes are coated and dry, urinary device (Prima-fit) is in place with clear/yellow urine draining into suction cannister, bowel sounds are active with liquid/tan stool noted, abdomen is distended with surgical scar, non-pitting edema is all extremities, patient can move all extremities and responds to commands, she ill-appearing and lethargic.

Wound Photos:



Braden Risk Assessment Tool	
Sensory Perception	3

Moisture	2
Activity	1
Mobility	2
Nutrition	3
Friction/Shear	1
Total	12 (High risk)

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)

-Assess bilateral lower extremity skin every shift for new bullae, bleeding, increased drainage, odor, or signs of infection (fever, hypotension, tachypnea, purulent drainage, increased swelling)

-Notify provider and WOC nurse for worsening skin integrity or uncontrolled bleeding

-Maintain off-loading boots and inspect heels for new non-blanching redness/breakdown (notify WOC and provider of changes)

-Ensure turning wedge is in place (lowest point to remain at hips); patient to be repositioned every 2 hours by nursing staff

-Cleanse lower extremity skin daily and as needed for soilage using Vashe wound cleanser or Normal Saline if Vashe is unavailable; pat areas dry, DO NOT SCRUB; for open areas cover with Aquacel AG, secure with kerlix and Medi-pore tape (tape only to be used on kerlix, NOT ON SKIN); Cut Aquacel to fit wound bed (do not overlap intact peri wound) daily and PRN for soilage

-For intact hemorrhagic bullae: Leave intact, cover with non-adherent contact layer if exposed to friction (Mepilex AG); monitor for ruptured bullae and notify WOC and provider for changes

-Apply Cavilon No Sting Barrier Film for intact peri wound skin daily

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-Absorbent underpad x 1 positioning to divert drainage and change absorbent pad when soiled

-Elevate bilateral lower extremities when in bed

-Avoid compression unless it is specifically ordered by provider

-Collaborate with dieticians to optimize protein and caloric intake to support wound healing

-Educate nursing staff on gently handling techniques and avoidance of adhesive products
-Maintain HOB 30-45 degrees (ensuring feeding is paused when patient in supine position)

-Maintain oral care per protocol (mouth care every 4 hours and as needed for increased dryness or secretions; notify WOC nurse and provider if increased or new breakdown is noted in mouth)

-Monitor skin under devices for breakdown every shift, notify WOC and provider of changes

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

This case highlighted the importance of tailoring wound care strategies to underlying hematologic and immunologic conditions. Traditional interventions such as debridement or compression were contraindicated. Earlier preventative measures, including proactive protective dressings and staff education on atraumatic handling, may have reduced progression of skin injury, Continued emphasis on prevention in high-risk populations is essential.

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?
To improve my assessment and management of hemorrhagic bullae and fragile skin in immunocompromised, thrombocytopenic patients.
Was it met? Why or why not?
Yes. I successfully completed a comprehensive assessment, contributed to development of a directive WOC plan of care, and reinforced prevention strategies with bedside staff.

What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)
To further develop expertise in differentiating hematologic-related skin failure from pressure-related injuries and to refine wound care product selection for medically complex patients.

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,	✓	

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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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