Daily Journal Entry with Plan of Care & Medical Record Note

Student Name: __Tiffany Wilson_____ Day/Date: __12/13/20_____

Directions: ***WOC nurses' function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment you are acting as a nurse specialist;*** select one patient each clinical day and complete ***plan of care and chart note.*** This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment. ***Include pertinent past medical & surgical history and medications.***	89-year-old male, PMH of a-fib, CAD, diabetes, and dementia. Patient is non-verbal and not oriented. Patient presented to emergency room via ambulance from nursing home for left-sided facial drooping.

Write a comprehensive and understandable medical record note for the medical record for this patient encounter.
Be sure to include specific products that were used/recommended for use:

WOC nurse consulted by primary nurse due to concerns for red skin on buttocks and perineal area after arriving from nursing home in urine-soaked brief. Chart reviewed with identification of urinary and fecal incontinence. Constant oozing of loose stool. External catheter placed by nursing. Appetite is poor and requires to be fed. Patient appears comfortable in bed positioned on back, with eyes open. Non-verbal and follows commands. Cooperative. Noted to have disposable blue underpad in place. Small amount of clear to yellow urine noted on underpad. External catheter in place and connected to gravity drainage. Draining yellow colored urine without sediment. Skin assessment notes intact, blanchable, erythema to perineal area. Pt repositioned onto left side. Noted to have loose, brown stool. Area cleansed with pH balanced cleanser and patted dry. No evidence of skin breakdown. Evaluation finds pt is appropriate for FMS. Male external fecal pouch applied to patient and attached to drainage bag. Clean disposable blue underpad placed under patient. Patient remains positioned on left side.

Assessment: Fecal and urinary incontinence

Recommendations:
-Hourly checks to include evaluation of incontinence devices
-Initiate bowel program to bulk stools if no medical contraindication
- pressure redistribution measure

WOC Nursing Problem pertinent to this visit	**WOC specific direction for other care providers such as**	**Rationale** ***(Explain why an intervention is***

	the bedside nurse, nurse assistants, etc. to follow.	***chosen; purpose)***
Impaired skin integrity due to fecal and urinary incontinence	Initiate bowel program to bulk stools if no medical contraindications. Apply external fecal pouch and external catheter. Hourly rounding to assess for incontinence and evaluation of external fecal pouch and external catheter. Document I&O. Empty fecal pouch when ½ full. Turn and reposition every 2 hours while in bed and hourly when in chair. Limit use of briefs. Utilize blue underpad for incontinence and moisture control. Cleanse skin with pH balanced skin cleanser after every incontinence episode. Order Low air loss mattress. Utilize waffle chair cushion for weight redistribution while in chair. Off load heels.	Bowel program promotes bulking of stool in order to decrease episodes of loose incontinent stools.
Impaired nutritional status due to poor appetite, requires max assistance with feedings	Consult nutrition. Licensed dietician to evaluate patient's nutritional needs and make recommendations. Monitor glucose levels and treat accordingly.	Adequate nutrition is important for healing and maintaining healthy skin. Tight glucose levels promote healing
Impaired mobility: new onset left sided facial droop, incontinence of bowel and bladder. Assistance required for repositioning and feeding.	Consult PT/OT to evaluate and make recommendations for safety and strength training. Speech consult to evaluate and make recommendations for safe swallowing.	Providing frequent repositioning and collaborating with PT/OT/ speech will help prevent deconditioning while hospitalized and prevent skin breakdown.
Increased risk for fall/injury due to new onset of weakness, incontinence of bowel and bladder, dementia limited mentation.	Provide a safe environment that includes bed rails up, bed in lowest position, personal belongings within reach, call bell within reach. Hourly rounding to assess for pt's needs Reorientation with assessments.	Appropriate support and communication with pt and family/caregiver is important in developing a plan of care.
Impaired communication: nonverbal, confused. Hx dementia, new onset of left sided facial droop.	NIH scale assessment at time of admission and reassessment time frames to be adjusted per stroke protocol.	

What are the disadvantages of using this product(s)?	External catheter disadvantage is increased risk for becoming dislodged and leaking to occur. Reassessment of skin is necessary to ensure no injury to skin occurs from constant pressure. Due to pt's altered mentation he is more likely to pull off device. An alternative device is to place an indwelling catheter. An external fecal pouch difficult to keep in place. These pouches are also limited to nonambulatory pts that don't slide up and down much in bed. While an external fecal pouch is in place rectal exams are unable to be performed and rectal medications can not be administered. It is difficult to effectively use these devices when there is already perianal skin breakdown because it is difficult to secure a seal. If the skin is already injured, at time of removal more injury can be caused. If stool continues to be loose an internal fecal management system can be inserted if not contraindicated medically. A FMS such as a Flexiseal can be inserted to collect stool. pH balanced skin cleanser. An alternative way to cleanse skin is to use soap and water. Application of 3M Cavilion skin protectant to incontinence impaired skin can be applied also to provide additional skin protection from frequent moisture caused by episodes of incontinence.
What alternative product(s) could be used and why?	

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	I was able to meet my learning goals by reviewing external and internal urinary and fecal management systems .
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I plan to continue reviewing treatment options and testing procedures for causes of urinary and fecal incontinence. Continue to work through on-line lessons and readings.

Number of Clinical Hours Today:

Care Setting: _ Hospital ___ Ambulatory Care ___ Home Care ___ Other: ___on line journal_____

Number/types of patients seen today: Preceptor:

Reviewed by: _____ Date: _____