

**Daily Journal Entry with Plan of Care & Medical Record Note**

 Student Name: \_\_\_\_\_ Courtney Podlecki \_\_\_\_\_ Day/Date: \_\_\_\_\_ January 15<sup>th</sup>, 2021  
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**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.**

<b>Today's WOC specific assessment. Include pertinent past medical &amp; surgical history and medications.</b>	89 year old male, PMH of afib, 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.
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**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

<b>WOC Nursing Problem pertinent to this visit</b>	<b>WOC specific direction for other care providers such as the bedside nurse, nurse assistants, etc. to follow.</b>	<b>Rationale (Explain why an intervention is chosen; purpose)</b>
Incontinence bowel and bladder  IAD	Keep patient clean and dry Change urine soaked briefs and under pads as soon as they are soiled- do not let patient stay prolonged in urine Cleanse with pH balanced cleanser at every	Keeping the patient clean and dry will prevent skin break down. Any type of urine or feces on skin for a prolonged period of time will irritate and break down skin

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<p>Lack of mobility due to cognition/ dementia</p> <p>Nutrition deficit</p> <p>Skin breakdown due to incontinence</p> <p>Male external fecal collection pouch</p> <p>External urinary catheter</p>	<p>change- pat dry Complete urinary catheter assessment every shift to prevent leaking and kinking Male external fecal collection system placed- observe every two hour for leaking/ incontinence Notify MD with change in condition/ decline</p> <p>Complete quality q2 hour turns making sure all bony prominences are elevated and off of the bed surface. Verify that no fecal/ urinary incontinence is left on the skin at any time when changing a patient Complete bathing and skin care each day (lotion daily and peri care every two hours when checking / turning and changing patient.</p> <p>Place PT referral for lack of mobility</p> <p>Keep patient awake during the day and sleeping at night to prevent delirium. Complete ROM exercises to prevent contracture</p> <p>Place patient in high fowler's position when eating and drinking.</p> <p>Notify MD with change in respiratory rate, SOB</p> <p>Place HOB in fowlers position 3x per day to pressure redistribute coccyx.</p> <p>Place only one sheet, pad and draw sheet under patient at any given time.</p> <p>Elevate head on a pillow or foam wedge</p> <p>Elevate heels on foam wedge or pillow at least 12 hours of the day when not up</p> <p>Place patient on pressure redistribution mattress instead of standard hospital bed mattress.</p> <p>Complete daily skin moisturizer to entire body to prevent dry cracking skin.</p> <p>Nutrition consult</p> <p>Recommend corpak and tube feed if lack of nutrition noted.</p> <p>Place patient on bowel regime 2x day. Add fiber and Imodium to morning and night medications</p>	<p>Cleaning with a pH balanced Cleanser will enhance clean skin and does not dry out from harsh chemicals. Frequent assessment of male external catheter by nursing staff will visualize leaks and malfunctions shortly after they occur so they are not left long enough to harm the patient by having stool and urine on the skin</p> <p>Q2 hour turns will pressure redistribute bony prominences so that a patient isn't laying in a position for too long to get a pressure injury Opting for a pressure redistribution mattress will alleviate pressure on bony prominences if patient is unable to turn himself.</p> <p>Proper bathing and hygiene will clean areas that are not able to be reached by patient. Oral care and nail care are important since the patient cannot manage these needs himself</p> <p>Early consult to PT will get the patient moving and prevent delirium. PT will prevent contractures in body.</p> <p>Keeping patient upright when eating will prevent aspiration and choking.</p> <p>HOB up after meals will prevent aspiration</p> <p>Limit amount of sheets and bulky bedding will decrease risk of wrinkles and skin break down from being on bed.</p> <p>Heels and elbows elevated on pillow or wedge will prevent pressure injuries and shearing/ skin tears to these bony prominences.</p> <p>Keeping skin moisturized daily will</p>
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	<p>to bulk stool without constipation</p> <p>Visually inspect catheter at every position change/ roll to verify catheter is secured to patient and urine is draining freely into the drainage bag.</p> <p>Inspect catheter and penis each shift for redness, swelling, odor, or drainage. Report to MD if any occur.</p>	<p>prevent drying and flaking.</p> <p>Adding a nutrition consult will prevent malnutrition and enhance proper healing. If the body is not nourished it cannot heal wounds and other issues going on.</p> <p>Male external fecal system placement and frequent monitoring of it will prevent feces from sitting on the skin and breaking it down.</p> <p>Bowel regime will prevent the need for fecal containment long term. Bowel regime will also bulk stool to more formed state to prevent dehydration.</p> <p>Extrenal catheter insertion will prevent urine from sitting on skin and under pads and breaking down skin. This method can also be used for long term incontinence management.</p> <p>Good peri care should be conducted to reduce the risk of infection.</p> <p>Visually inspecting that catheter is secured every shift will lessen the risk of UTI from it migrating.</p>
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<p><b>What are the disadvantages of using this product(s)?</b></p>	<p>Disadvantage of external fecal collection pouch and external urinary catheter are they do not hold very well. If the patient is alert, they will often times try to remove these. They are not secured with a balloon like the indwelling type, so they are easy to rip off. They can be placed for longer term management and to keep the skin clean and dry as possible.</p>
<p><b>What alternative product(s) could be used and why?</b></p>	<p>An alternative to these would be FMS and indwelling urinary catheter. FMS is only intended to be used for 29 days and a bowel regime should be established by then to form stool and obtain regularity. Indwelling catheters have a much higher infection risk than condom catheters but have much higher success rates than condom catheters. These could both be used if good seals were not being obtained or if too much leaking or pulling occurs causing disruption of therapy.</p>

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

<p><b>Were you able to meet your learning goals for today? Why or why not?</b></p>	<p>Yes- I was able to learn about the acute reasons that FMS and urinary catheters are placed. I also learned that catheters are acceptable reasons to prevent IAD in cognitively impaired patients. I learned more about the FMS and pressure redistribution when one is present.</p>
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<b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b>	I would like to learn more about catheters and why some get changed monthly, why some get irrigation. I know the difference between coude and regular and when to use those, but I would like to learn more about the mushroom type and when to use.
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Number of Clinical Hours Today:

Care Setting:  Hospital     Ambulatory Care     Home Care     Other:  Virtual \_\_\_\_\_

Number/types of patients seen today: \_\_\_\_\_ Preceptor: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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