Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Nicole Schroeder_____ Day/Date: ___5/12/21_

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, s***elect 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	**PMH:** 60 year old female with unknown medical history who presented to ED after being found lying on the couch unresponsive. Length of time is unknown. Paramedics arrived and were able to revive patient. Patient responsive in ambulance, confused. Labs significant for K 3, bicarb 19, lactate 2.9, CT and MRI head positive for stroke. **Surgical history:** No surgical history on file, patient confused and unable to give accurate history at this time due to confusion **Medications:** Sodium bicarbonate 650mg PO two times a day after meals Rifaximin 550mg PO two times a day Lactulose 20g/30mL PO every 6 hours On Heparin gtt

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

WOC Nurse Initial Wound Referral for breakdown to coccyx/sacral area.

Pt is 60 year old female with unknown medical history who presented to ED after being found lying on the couch unresponsive. Length of time is unknown. Paramedics arrived and were able to revive patient. Braden Score 15 per nursing. On First Step Mattress. Pt resting in bed. Calm and cooperative. Alert to name. Follows commands. Explained plan to pt. Pt turned onto left side. Assessment notes blue pad soiled with liquid brown stool. Nursing staff indicates pt continuously oozing stool with occasional urinary incontinence. Cleansed perianal area with periwipes. Perianal area with erythema. Skin breakdown to coccyx area superficial tissue loss and measures 3.5cm x 2cm. Unable to appreciate depth. Wound base is red. Periwound macerated, without satelite lesions. Few external hemorrhoids noted surrounding anus. Gloved, lubricated finger inserted into rectum. Pt asked to clench down on finger. Moderate rectal tone noted and no stool obstruction palpated. Nursing indicates pt does get up to chair with assist of 2 two to three times per day. Needs assistance with

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Recommendations:

- External fecal incontinence collector while pt has liquid stools and is unaware of stooling
- Consider use of FMS if unable to maintain external fecal collector
- Zinc barrier to area of IAD
- Begin toileting program
- Re-consult WOC RN if unable to maintain pouch

Will follow at intervals.

WOC specific medical & nursing diagnosis	**WOC Plan of Care (include specific product used today)**	**Rationale *(Explain why an intervention is chosen; purpose)***
Breakdown to coccyx / sacral area: Incontinence Associated Dermatitis Fecal incontinence	Apply external fecal incontinence collector while patient has liquid stools and is unaware of stooling. Cleanse perianal area with periwipes and allow to dry Trim perianal hair if it will prevent proper adhesion of the barrier Spread the buttocks apart, exposing the rectum, and apply the wafer and pouch. Make sure there are no gaps or creases Do not cover the labia Hold barrier with heat from the hand for 30 seconds to 1 minute Replace every one to two days and as needed for leakage. Check device twice a shift to make sure area is dry Notify WOC Nurse if barrier is not sticking or if leaking is occurring. Gently cleanse area of skin breakdown with	To contain feces and avoid further skin breakdown Periwipes are moist wipes usually impregnated with a skin protecting element. It is a good choice to use for cleansing for it's 3-in-1 function – clean, care and protect. Hair may cause the barrier to not stick properly Gaps or creases could cause leakage The labia needs to remain exposed To activate the adhesive bond May need to consider internal bowel management system if external collector cannot be maintained If area does not stay dry this exposes the patient to greater risk for worsening of breakdown Gently cleanse to avoid more breakdown Zinc Oxide has antiseptic properties,

	periwipes and apply Zinc barrier cream twice daily and when there are any episodes of leaking stool. Notify WOC Nurse if erythema worsens, if the area of superficial tissue loss is becoming more widespread, if there is any deep tissue loss, or if any satellite lesions appear. Begin toileting program Continue with First Step Low Air Loss Mattress Turn and reposition every 2 hours Keep the head of the bed up less than 30 degrees	calms skin & creates a barrier May need WOC Nurse reassessment to change Plan of Care To prevent pressure injury or worsening of injury. A low air loss mattress consistently pumps air to make the movement of the pressure rotate between the various chambers. These chambers are designed with small ventilation holes. The holes allow air to circulate within the mattress, and prevent stagnation which prevents heat and moisture that can increase the risk of pressure injury development by creating a damp, warm, stagnant environment. The constant flow of air created by the low air loss design helps keep the body cool and dry. To prevent pressure injury To prevent shearing of skin from sliding down or the need to be pulled back up.

What are the disadvantages of using this product(s)? What alternatives could be used and why?	External fecal incontinence collector: Use is limited to nonambulatory patients. Usually requires two clinicians to apply device. Stool can undermine the device and cause further breakdown. Rectal medication cannot be administered. Cannot use effectively if there is current perianal skin breakdown because you need intact skin to secure the seal. Periwipes: Can at times cause irritation, check the ingredients. Zinc: Can be difficult to remove, may cause irritation. First Step Low Air Loss Mattress: Recommended that you use flat sheets because they do not affect pressure within the mattress air cells like fitted sheets do. Air mattresses have soft edges that may collapse when patients roll to that edge resulting in a fall. Electrical machine that may need troubleshooting if not working properly. Internal bowel management system: This patient already has skin breakdown and IAD and the external device may not work due to this. An internal device will reduce the risk of further breakdown and allow the periarea to heal. Aloe Vesta Perineal and Skin Cleanser by Convatec: No-rinse spray formula for convenient patient care and less rubbing, cleansing agents dissolve soils and are pH- balanced. Coloplast Critic-Aid Clear Barrier Ointment: Clear moisture barrier, CMC allows product to adhere

	to intact, eroded and wet, weepy skin. Petrolatum provides the strongest protection against irritants and helps avoid maceration. Dimethicone hydrates and conditions the skin and allows for easy application and removal. Alternating Pressure Mattress: these mattresses have bladders positioned laterally or length-wise that slowly deflate and inflate, one at a time. This keeps the pressure points alternating throughout the body. Uses pressure redistribution to stimulate blood flow. The air cells on the mattress slowly inflate and deflate under the patient at a predetermined or adjustable cycle time.

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 hoping to learn more about external and internal fecal management devices and IAD prevention and treatment
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	More about internal fecal management devices

Number of Clinical Hours Today:

Care Setting: X Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __ Preceptor: _____

Reviewed by: _____ Date: _____

**References are not generally required for daily journals

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