Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Shannon McNamara- LaVolpa Day/Date: September 9, 2021

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***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	**PMH:** 22 year old female with unknown medical history who presented to ED after being found lying on the couch unresponsive for 24 hours by her roommate. Paramedics arrived. Roommate reported frequent drug use with recent known use of meth. Patient was given Narcan 2mg en route to ED. In the ED, patient was only responsive to painful stimuli with sonorous breathing. Code stroke was activated, and patient was intubated for impending airway compromise. Labs significant for K 2.4, bicarb 19, lactate 2.9, myoglobin 113, UDS opiates positive (given fentanyl in ED), ammonia 226, and biliruben 2.9. CT and MRI head negative for stroke. Altered mental status likely due to hepatic encephalopathy and patient started on lactulose and rifaximin. **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

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 Referral to reinsert internal fecal management system

Pt is 22 y/o female with unknown medical history who presented to ED after being found lying on the couch unresponsive for 24 hours. Given Narcan 2mg en route to ED. Responsive only to painful stimuli with sonorous breathing. Intubated for impending airway compromise. Extubated at this time. Braden Score 16 per nursing. On First Step Mattress, Alb 2.3, BMI 27.1 FMS noted to have been utilized for 15 days. Nurses notes indicate system noted to be out when pt turned. Pt resting in bed.

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Calm and cooperative. Alert to name. Altered mental status believed to be related to hepatic encephalopathy. Follows commands. Explained plan to pt. Pt turned onto left side and placed in knee chest position. Noted to be soiled with liquid stool brown/yellow. Nursing staff indicates pt continuously oozing stool. Cleansed perianal area with periwipes. Perianal area without redness or skin breakdown noted. 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. FMS reinserted and balloon inflated. Connected to gravity drainage. Bedside RN reports frequently urinates due to medications, sometimes incontinent. Noted to have moist deep red denuded blanchable skin to perineum, upper and inner ¼ of thighs, perineal area. Noted scattered raised papules of perianal area, with satellite lesions.

Recommendations:

Continue with internal fecal management system while pt has liquid stools and is unaware of stooling to prevent moisture associated skin breakdown.
Maximum use of FMS is 29 days.
Monitor for leakage of stool surrounding fecal
Re-consult WOC RN for excessive leaking
Cleanse red areas gently with no rinse peri-cleanser after each bedpan use or incontinent episode.
Apply Critic Aid Clear AF skin barrier (AF-2% miconazole nitrate) to red area.
Do not use briefs unless ambulating
Keep bed linens to one bed sheet, one open draw sheet and one absorbent pad under patient
Use mechanical lift when moving patient up in bed
Roll patient to place or remove bedpan

WOC specific medical & nursing diagnosis	**WOC Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: ***Risk for impaired mobility due to current health condition*** ***Imbalanced nutrition: less than body requirements as evidenced by low albumin*** ***Altered bowel elimination as evidenced by FMS***	1. Turn every two hours in bed. 2. Continue First Step low air loss mattress. 3. Order heel protecting boots and prop heels on pillow. 4. Keep head of bed at 30 degrees. 5. Nutritional consult for low albumin level and risk of malnutrition. 6. Continue use of FMS in for 14 more days while stool is liquid and patient unaware of defecation. Only use the same FMS for 29 days. 7. Check the FMS every 2 hours to ensure the device is positioned properly against the rectal floor and that is not	1. Patient needs to be turned every 2 hours for she is on bedrest and at mild risk for acquiring a pressure injury as evidenced by her Braden score of 16. 2. A low air loss mattress will continuously relieve pressure while contributing airflow for moisture management. 3. Heel protector boots will ensure heels remain free of pressure and pillows underneath them will make

Altered urinary elimination as evidenced by voiding on bedpan/incontinence ***Impaired tissue integrity as evidenced by perineal breakdown***	obstructed. 8. To ensure unobstructed flow, verify that the catheter is not twisted, kinked or externally compressed. Make sure that feces is not accumulating in the catheter drain tube. If it accumulates, irrigate as needed following manufacturer's instruction. 9. Monitor for stool leakage around FMS. Reconsult WOC nurse for excessive leaking and if unable to resume flow after irrigation. 10. Ensure tubing lay between patient legs. 11. Carefully roll patient on and off bedpan as to not dislodge FMS. 12. Use mechanical lift to move patient up in bed as to not dislodge FMS. 13. Notify physician with rectal bleeding. 14. To skin to perineum, upper and inner ¼ of thighs, perineal area – complete care with every bedpan use or incontinent episode. 15. Gently cleanse using no rinse peri cleanser. Pat dry. 16. Apply Critic Aid Clear AF skin barrier (AF-2% miconazole nitrate) to red area. 17. Do not use briefs unless ambulating. 18. Only use one bed sheet, one open draw sheet and one absorbent pad under patient.	double sure of that. 4. Keeping head of bed at 30 degrees will reduce risk of shearing forces from sliding down in bed. 5. Patient is at risk for imbalanced nutrition as evidenced by her albumin level of 2.3. A diet was not specifically stated or given in this case study, but patient should have nutrition on consult even though her BMI is 27.1. I assume she is receiving IVF as well to keep hydrated for patient is losing a lot of fluid with the continues oozing of stool. 6. FMS are intended for one time use, if they come out prior to 29 days, they can be immediately rinsed and reinserted. 7. Frequent monitoring is necessary in these patients to ensure stool is properly flowing and there are no obstructions. 8. Irrigation is necessary if stool is not flowing and the nurses should be able to irrigate if necessary. However, if unable to relieve obstruction via irrigation – they should reconsult WOC nurse to troubleshoot for device might have to be discontinued. 9. Some stool tends to leak when using FMS, but excessive leaking is when WOC nurse needs reconsulted to troubleshoot device. 10. Making sure the tubing is in between patients legs ensures that patient is not laying on it which could cause pressure injury as

		well as laying on it could cause obstruction of flow. 11. Carefully rolling patient on and off the bedpan to urinate will help to not dislodge the FMS. 12. Using mechanical lift is necessary to not dislodge FMS. 13. There is a higher bleeding risk among patients on anticoagulants/antiplatelets and as a result of inadvertent traumatic removal, so if bleeding is persistent, MD needs notified. 14. For wound care, its necessary to be completed every time the patient uses the bedpan or is incontinent of urine or has stool leakage to protect the perineal skin from further breakdown. 15. Using a no rinse peri cleanser is pH balanced and gentle on the skin as well as convenient for staff so they don't have to worry about washing soap off and drying skin. 16. The stools liquid nature has enzymes that cause breakdown of skin. So using Critic Aid AF will be a protective barrier against moisture as well as treat the patient's fungal infection as evidenced by scattered raised papules with satellite lesions. 17. Briefs are not to be used unless ambulating because they hold in moisture and contribute to skin breakdown. 18. The one absorbent pad will be able to collect the patients incontinence with letting her perineal skin breathe. Using the least

		amount of bedsheets as possible helps keep patient dry – so one bedsheet to protect the mattress, one lift pad to help patient roll onto bedpan.

What are the disadvantages of using this <u>product(s)</u>? What alternatives could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	***Disadvantages of using FMS is that it can cause rectal bleeding if accidentally expelled, and this is dangerous for people who are on anticoagulants and antiplatelet medications – which many of the people who have an FMS in are.*** ***There are 2 other internal bowel management systems, rectal tubes and rectal trumpets. However, both of them are now unacceptable to use and considered unsafe due to risk for rectal necrosis, bowel perforation, and damage to anal sphincter.*** ***One can use an external fecal collector, which is like an ostomy pouch with a hydrocolloidal skin barrier with a long pouch that collects large amounts of stool with a spout closure at the end. They are actually recommended as the first step in management of large volume liquid stool. However, it is more difficult to contain an effective seal if the perianal skin is denuded.*** ***Disadvantages of using a no-rinse perineal skin cleanser are that it does not really deep clean area. One could potentially use more force trying to remove dried on fecal matter and cause more perineal skin breakdown doing so.*** ***An alternative would be just antibacterial soap and water. Soap plus water can help to loosen up fecal matter so one doesn't have to exert as much force trying to remove dried on fecal matter from skin.*** ***Disadvantages of using Critic Aid AF are blistering, burning, redness, skin rash, or other signs of skin irritation not present before use of this medicine*** ***An alternative would be Nystatin powder – it will help dry denuded skin as well as is antifungal.*** ***Disadvantages of using briefs are that most briefs carried by the hospital (most of them do not offer them anymore, due to many studies which show they do more harmful then good) are plastic material and they hold is moisture which can contribute to further skin breakdown.*** ***There are no alternatives to briefs, so the best alternative is to not wear one and to just keep 1 absorbent pad underneath patient and change with each incontinent episode or if perspiration gets on it.***

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 goals for today! I think I was more directive in my care plan and specific to patients needs. I made my sentences shorter and easier and more concise for the nursing staff to follow.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Learning goals for tomorrow include to become more knowledgeable on continence specific surgical procedures

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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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