Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Medical Record Note

Student Name: Vanessa Rittle Day/Date: August 16, 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 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 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.

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 Directive Plan of Care (Base this on the above data. Include specific products)**	**Rationale** ***(Explain why an intervention was chosen; purpose)***
Altered skin integrity related to incontinence Imbalanced nutrition r/t poor appetite Reduced mobility	Continue with external urinary catheter. Check device hourly for placement, skin health, tissue damage, signs of UTI or kinked or ill placed tubing, that prevents proper flow of urine. Change and provide perineal care daily. If patient pulls at device, discontinue its use and	External urinary catheter, such as a condom catheter are a suitable choice for men who are incontinent. When applied and cared for appropriately, they can protect skin integrity from breakdown.

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	provide incontinence care to include placing a pad under the patient, gently cleansing with a pH balanced cleanser, pat dry and apply zinc oxide after each incontinence episode. Monitor for signs of skin breakdown. If any noted, reconsult WOC nurse. Continue with fecal pouch. Check device hourly for placement and for any signs of breakdown to skin under device. Replace every 2 days (more often if area of redness is not improving) or as needed for leakage. Provide perineal care in between changes to include gentle cleansing with a ph balanced soap and pat dry. If skin breakdown is noted or device no longer contains stool, discontinue its use and provide skin care after each incontinent episode. Reconsult WOC nurse if any skin breakdown is noted. May use brief only during ambulation, if needed. Keep bed linens to one bed sheet, one draw sheet and one absorbent pad under patient Turn patient q2 hours and assess for signs of tissue damage. Place preventative foam dressing to coccyx and heels. Float heels. Place patient on a LAL mattress Feed patient and encourage fluid and nutritional intake. (if appropriate after swallow eval). Record percentage of meals eaten and fluid intake. Consult nutrition. Mobilize patient, when appropriate Administer po Imodium (or other anti-motility agent) as ordered, if appropriate (after swallow evaluation)	This patient has dementia and is not oriented, so if he pulls on the catheter or moves in a way that can pull on the catheter, serious penile trauma or skin damage can occur, so this should be discontinued if deemed not appropriate. A fecal pouch is a good way to contain stool and avoid breakdown to the perianal skin. This is no longer appropriate if the skin is no longer intact. If the fecal pouch/condom catheter is no long appropriate, a brief can used for ambulation to contain stool/urine, but should not be used any other time d/t its tendency to hold moisture against the skin. Limited linens/pad under patient reduces the risk of friction/shear/wrinkling under the skin. Patient should be turned frequently and placed on a LAL mattress to reduce the chances of pressure injury to bony prominence. Mobilization helps prevent pressure injuries due to less time in one position. Encouraging intake will aid in calorie intake and help prevent weight loss. Pt came in with left sided drooping, so swallowing may be a problem and should be addressed prior to administering any po. Recording percentage of meals and fluid intake can help the dietician determine if patient is getting adequate nutrients/hydration.

		Slow intestinal transit time promotes absorption of nutrients and electrolyte balance. It also helps avoid dehydration and the breakdown of skin caused by loose stool.

What are the disadvantages of using this product(s)?	The disadvantages of using an external fecal pouch are that they can't be used if the patient becomes ambulatory, it requires more than one caregiver to apply and stool can seep under the pouch and cause further skin breakdown if not caught in a timely manner.
What alternative product(s) could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	An alternative to an external fecal pouch, is an internal bowel management system. This system can better protect the perianal skin, that's already compromised (redness).

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?	Yes, I was able to continue to apply knowledge gained during this course to a patient scenario.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goas are to continue to apply knowledge and continue to develop individualized plans of care.

Number of Clinical Hours Today:

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

Number/types of patients seen today: Preceptor:

Reviewed by: _ _____ Date: _____

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