Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Day/Date: _____

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:** 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. Calm and

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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 peri wipes. 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.		
1. Acute Confusion related to hepatic encephalopathy.	1. Continue with Lactulose 20g/30mL PO every 6 hours until ammonia levels are Less than 30 micromol/L, Rifaximin 550mg PO two times a day prophylactic for infection and Sodium bicarbonate 650mg PO two times a day after meals until blood pH levels are at 7.35 - 7.45. Assess the client's behavior and cognition systemically and continually throughout the day and night; Use a validated tool to assess presence of delirium, such as the Confusion Assessment	1. When patients' ammonia levels are high, it negatively affects the brain causing confusion, lactulose is a common medication used to decrease the ammonia levels in the blood. When patients have electrolyte imbalances due to fecal incontinence, it causes their blood levels to become acidic. Sodium

	Method (CAM) or Delirium Observation Screening Scale (DOS). Provide cognitive stimulation though conversation about current events, viewpoints, relationships and encourage reminiscence or word games.	Bicarbonate acts as a buffer solution neutralizing the blood pH levels. Antibiotics are given prophylactically to help decrease bacterial load allowing the body to focus on healing but also question MD if this could be contributing to the diarrhea.
2. Fecal and urinary incontinence related to altered mental status.	2. Continue with fecal management system (FMS) for 14 more days then discontinue. If client continues with episodes of incontinence and excessive leakage, reconsult with the wound care nurse. Educate nursing staff how to properly inflate the rectal cuff and ensure proper placement. Place order for external female catheter use, until client gains the ability to call for assistance. Turn and reposition Q 2 hours with pillow support to offload and air out denuded and macerated skin and to prevent pressure injuries (PI). During this time check for episodes of incontinence. After episodes of incontinence or seal leakage, clean peri area with ReadyCleanse Perineal Care Cleansing Cloths by Medline and apply Critic Aid Clear AF skin barrier by Coloplast. Do not place client in adult diapers until client is ambulatory. Keep bedlinen limited to one bed sheet, one draw sheet and one under pad. Consult a dietician to review the client's nutritional history and evaluate methods to normalize stool constancy with dietary adjustments and to address low albumin levels. Place order for external female catheter use, until client gains the ability to call for assistance. Check to insure there are no kinks or blockages to both the FMS and the external catheter. Educated client to call when the need to void occurs and encourage the use of a bedpan or bedside commode when appropriate. Promote early mobilization and rehabilitation in a progressive manner.	2. The best way to prevent/treat IAD is with a “structured skin care regimen.” It also helps to prevent and treat skin irritation and inflammation caused by exposure to urine and feces. This type of skin irritation can lead to redness, itching, and pain, and if left untreated, it can progress to more serious skin conditions such as infections or ulcerations. A structured skin care regimen can include cleansing the skin with mild, non-irritating products, applying skin protectants to create a barrier between the skin and the irritants, and using emollients to soothe and moisturize the skin. It is important to follow this regimen consistently in order to effectively manage and treat IAD.

What are the disadvantages of using this product(s)? What alternatives could be used	Some disadvantages to using a FMS are becoming too reliant on the product and neglecting to check if it's properly secured and free of kinks. Another downside to this type of system, they can become cumbersome to clients that are starting to ambulatory and may pose as a trip hazard. I would also think homarids would cause an issue with catching a good seal on the rectal wall.

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and why? (This is your opportunity to share your product knowledge and apply critical thinking)	This client may benefit from the use of a Fecal Collector Pouch Flexi-seal® - Fecal Col by Convatec. In order to help the device stick to the skin, it may behoove the nurse to use the "crusting technique" to form a seal. This technique involves placing Adapt Stoma Power by Hillister to the base of the skin and dust off any access. Then apply Cavilon Barrier Film by 3M to cover, this will give the adhesive basking on the bag something to stick to.

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 learned the contraindication to FMS; Stool soft, pasty, hard or formed, Suspected or confirmed fecal impaction, Sensitivity or previous allergic reaction to product components (i.e. silicone), Rectal or lower large bowel surgery within the last year, Inadequate anal tone to retain device, Suspected or confirmed anal/rectal mucosal impairment or injury, Rectal or anal tumour, stricture or stenosis, Coagulopathy (platelets less than 50 x109/L, or INR greater than 1.5, or PTT greater than 2X control value), Neutropenia (neutrophils less than 1x109/L), Patient is ambulatory or sitting out of bed and Patient is C. difficle positive and at risk for perforation or toxic megacolon.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Learn what products I have at my clinic to treat IAD and reinforce my understanding of IAD treatments.

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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