Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Paula L. Vaughn Journal Completion Date: _____

Setting: __X___ Acute Care _____ Outpatient _____ HHC ____ Other _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

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. 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 **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	

Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and 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 and was intubated. Pt now extubated. Braden Score 16 per nursing. On First Step Mattress, Alb 2.3, BMI 27.1 FMS has been in place for 15 days. Nurses notes indicate system

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found to be out when pt turned. Pt resting in bed. 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. Buttocks and pads 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. 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 upper and inner ¼ of thighs and perineal area. Scattered raised papules on 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 FMS
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 reddened areas.
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 and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***	**Statements should be directive and holistic relating to the problem/concern.**	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.**
IAD consistent for candidiasis secondary to urinary and fecal incontinence	Cleanse skin with pH balanced skin cleanser, using a non-abrasive washcloth. Apply product containing zinc oxide such Calmoseptine, Maximum strength Boudreaux's butt paste, followed by antifungal powder.	The more neutral pH the more balanced wash, less acidic to the skin. Zinc has anti-inflammatory properties and increases reepithelialization supporting its

		use for treating eczemas. Protect the skin from irritation.
Urinary incontinence related to hepatic encephalopathy as evidenced by red denuded blanchable skin to thighs and perineal area.	Utilize briefs made of superabsorbent polymer and may be used along with a booster pad to assist in moisture control, they must be changed in optimal time frame after incontinence episode. (BWAP)	Protects against skin breakdown and IAD.
	Foley Catheter could be placed. PureWick could be placed.	Monitor close urine output and help control urine to prevent skin exposure to urine.
Fecal incontinence secondary to medication and encephalopathy	Frequent FMS checks for leakage because leakage would cause skin injury. Also, verify that waste is not accumulating in the catheter drain tube; if waste accumulates, irrigate as needed following manufacturer's instruction.	Protects against skin breakdown or pressure related injury from medical equipment.
	Check the Stool Management System q2hr to ensure the device is positioned properly against the rectal floor and that it is not obstructed.	To reassure the FMS is properly emptying to assist in avoiding build up of waste which increases risk of leaking. Irrigation can assist with decreasing the possibility of leakage.
	Document patient assessment, record stool management system type and purpose, date and time stool management system inserted, then amount, color and consistency of feces collected and patient response to the system.	Monitors the patient's outputs, the length of FMS usage (which should not exceed 29days).
Altered mental status as evidenced by hepatic encephalopathy.	Assess and monitor level of consciousness. Monitor blood work. Reorient patient as needed. Engage the family to assist with reorientation. Provide fluid and electrolytes. Maintain a calm environment.	Monitors patients' orientation and consciousness. Monitoring ammonia levels, BUN and creatinine, urinalysis, white blood counts these abnormalities in the liver, kidneys, and infectious processes can reveal contributing factors to symptoms of confusion.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Disposable BWAP disadvantage: May cause breakdown of skin or irritation if not change in a reasonable manner. Alternative: Cloth bed pad

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product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	Zinc based products disadvantage: Zinc based products may be difficult to remove. Alternative: Marathon skin protectant. Foley Catheter disadvantage: Infection risk, patient could cause injury if she pulls on the catheter. PureWick disadvantage: Could cause skin irritation or breakdown if not replaced every 8-12 hours, patient could displace the purewick due to her altered mental state, then have wetness under her and the staff may not change the wet pad and she may gain skin breakdown from wetness. FMS disadvantage: If the balloon is overinflated can cause damage to rectal wall such as bleeding, ischemia, fistula formation, rectal tone loss. Alternative: External fecal collection pouch.

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

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal of this mini case study was to learn more about treating IAD and incontinence. I did meet my goal. I feel I met my goal by learning the difference in the active ingredients in the creams and the different options for managing fecal incontinence.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To continue to learn about urinary and fecal incontinence management.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This was a great review of the FMS and management and how I could manage incontinent stool for the patients at home more broadly. I will be able to discuss the different barrier options more openly with the patients understanding the active ingredients in the creams.

Reviewed by: _____ Date: _____

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