

**Daily Journal Entry with Plan of Care & Chart Note**

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 Setting:  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.

<b>Today's WOC specific assessment</b>	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.
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**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 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. History of urinary and fecal incontinence, poor appetite requires to be fed. Patient appears comfortable in bed positioned on back, with eyes open. Non-verbal and follows commands. Cooperative. Prior to this visit, nursing placed an external urinary catheter and connected to gravity drainage. Draining yellowed colored urine without sediment. Skin assessment notes intact, blanchable, erythema to perineal area. Pt repositioned onto left side. Constant oozing of 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 containment devices
- Initiate bowel program to bulk stools if no medical contraindication
- pressure redistribution measures

WOC specific medical & nursing diagnosis and concerns	WOC Plan of Care (include specific products used)	Rationale (Explain why an intervention is chosen; purpose)
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Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns.	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.
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<p><b><i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></b></p> <p>Functional urinary incontinence related to impaired physical mobility.</p> <p>Diarrhea possibly caused by malnutrition.</p> <p>Impaired skin integrity evidence by intact, blanchable, erythema to perineal area.</p>	<p>Hourly checks to include evaluation of containment devices. Continue to utilize the external urinary and external fecal management system.</p> <p>Initiate bowel program to bulk stools if no medical contraindication.</p> <p>Area cleansed with pH balanced cleanser and patted dry when elimination is cleansed from skin. Continue external urinary catheter and continue connection to gravity drainage. Expected wear time for external catheter is 1-2 days then apply a new one. Continue pressure redistribution measures, reposition patient every two hours.</p>	<p>Hourly checks will ensure the patient is dry, clean, and the containment devices are in place and working. The containment devices will collect the urine and stool for adequate I/O along with protection of the skin from MASD.</p> <p>This will decrease the possibility of the patient having MASD, perianal excoriation and bed sores, gives patient the possibility to be able to utilize a bed pan.</p> <p>Cleansing with a balanced pH cleanser allows the skin to keep up its defense while preventing irritation. Utilizing the external catheter is a defense against MASD and pressure injury by keeping the patient dry. Reposition to decrease possibility or pressure injury.</p>
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<p><b>Identify each WOC product in use/identified in POC. State at least one disadvantage of the product. Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?</b></p>	<p><b>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</b></p> <p>Condom catheter Disadvantage: easily displaced and then the patient suffers with leakage of urine. Alternative: Medline men's liberty acute external catheter with cathgrip securement device.</p> <p>Blue under pad Disadvantage once becomes soiled the wetness lays under the patient and places patient at risk for MASD and pressure injuries. Alternative: Tena disposable pads they are soft pads that are ingrained with superabsorbent beads.</p> <p>Pressure reduction Disadvantage: If patient is not placed on an adequate schedule with a turn team, the pressure reduction by reposition every two hours will not work. Alternative: Can help, but still will benefit from assistance from staff: utilize off loading air mattress or over lay off loading mattress.</p>
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**Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.**

<b>What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?</b>	<p>My goal for choosing this mini case study was to learn more about the external collection devices. I did meet my learning goal. I figured out multiple different types of external catheters and how to apply them for the male patient.</p> <p>I also learned if the external fecal pouch is leaking, must remove the system, cleanse the area and reapply a new pouching system.</p> <p>May recommend increasing fiber in the patient's diet to thicken the stool output. May assist the patient with foods such as oats, peas, beans, apples, citrus fruits, carrots, barley.</p>
<b>What are your learning goals for tomorrow?</b>  <b>(Share learning goal with preceptor)</b>	<p>To continue to learn more detail in the continence world.</p>

<b>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</b>	<p>I recommend signing this patient up on the turn team to be sure he is being repositioned every two hours along with being checked for incontinence. That way if his external devices are not functioning well he can be cleaned and new devices may be reapplied at that time.</p>
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Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

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