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: 1/28/2023

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:** 60 year old female with unknown medical history who presented to ED after being found lying on the couch unresponsive. Length of time is unknown. Paramedics arrived and were able to revive patient. Patient responsive in ambulance, but confused. Labs significant for K 3, bicarb 19, lactate 2.9, CT and MRI head positive for stroke. **Surgical history:** No surgical history on file, patient confused and unable to give accurate history at this time **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 On Heparin gtt

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 Initial Referral for breakdown to coccyx/sacral area.

Pt is 60 year old female with unknown medical history who presented to ED after being found unresponsive on the couch for an unknown amount of time. Paramedics able to revive patient. Braden Score 15 per nursing. On First Step Mattress. Pt resting in bed. Calm and cooperative. Alert to name. Follows commands. Explained plan to pt. Pt turned onto left side. Blue under pad soiled with liquid brown stool. Nursing staff indicates pt continuously oozing stool with occasional urinary incontinence. Cleansed perianal area with periwipes. Perianal

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area with erythema. Superficial tissue loss to coccyx area measuring 3.5cm x 2cm x 0.25 cm. Wound base is red. Periwound macerated, without satellite lesions. 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. Nursing indicates pt does get up to chair with 2 person assist two to three times per day. Needs assistance with turning.

Recommendations:

- External fecal incontinence collector while pt has liquid stools and is unaware of stooling
- Zinc barrier to area of IAD
- Begin toileting program
- Re-consult WOC RN if unable to maintain pouch for reevaluation and possible FMS placement

Will follow at intervals.

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.**
Fecal incontinence related to diarrhea most likely secondary to medication such as Rifaximin and Lactulose.	Place external fecal pouching system to manage the fecal incontinence. Change pouch every two days and when leakage occurs. Cleanse skin with periwipes with each peri area cleansing and pouch change.	This will control the fecal incontinence and protect the skin. The periwipes help maintain healthy clean skin.
Impaired skin integrity evidenced by perianal area erythema and superficial tissue loss to coccyx with red base, periwound maceration, and satellite lesions which is most consistent with candidiasis infection.	Continue to assess the peri area skin every two hours when repositioning the patient. Assess for ongoing or worsening redness and pressure. This patient has erythema and tissue loss already, that is evidence of Stage 1 and 2 pressure injury. Continue to use the 1st step low air loss mattress, assist patient with turning every two hours, and assist patient to the chair three times a day. May utilize blue pad but must check the pad for soilage every two hours and change as necessary.	Decrease the possibility of worsening pressure injury. Protects against worsening pressure ulcers. Helps assess and watch for worsening pressure injuries. Helps off load to protect from pressure injury. Keeps patient clean and dry which reduces chance for MASD and pressure injury.

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IAD evidenced by perianal area erythema secondary to occasional urinary incontinence.	Utilize zinc barrier paste after cleansing the skin. Begin toileting program, assist patient to the chair three times daily and assist to the bedside commode. The toileting program should appear close to The patient should empty her bladder first thing in the morning. Then schedule times through the day such as every hour, even if the patient may not need to go. Slowly increase the time between trips to the restroom such as every one hour to two from two to four. Would not recommend going for longer than four hours. Once a schedule is discovered that is comfortable for the patient, then she will continue that schedule for a while.	Protects skin from MASD. Toileting program can reduce problems with urgency or incontinence.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> 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?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** FMS Disadvantage: This patient has external hemorrhoids- so FMS should not be utilized. Alternative: external fecal pouch. Periwipes Disadvantage: Sometimes they are not pH balanced and may cause skin irritation. Alternative: Cleanse with soap and water. Repositioning every two hours Disadvantage: Staff may not be able to stay on scheduled time. Utilize foam bordered dressings to pad boney prominences. Utilize zinc with a dusting of miconazole powder to treat the satellite lesions on the perineum.

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

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 for this mini case study was to learn more about toileting program along with looking over indications and contraindications for external fecal containment device vs FMS. I did reach my goal today, I refreshed my memory that an FMS is not able to be utilized if the patient has hemorrhoids.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To continue my learning about treating continence.

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Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	I do not feel I would do too much different in this scenario except I would not use an FMS due to the hemorrhoids. May utilize soap and water rather than the peri wipes.

Reviewed by: _____ Date: _____

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