Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

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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	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.

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)**

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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NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc		
Functional urinary incontinence related to impaired physical mobility.	Hourly checks to include evaluation of containment devices. Continue to utilize the external urinary and external fecal management system.	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.
Diarrhea possibly caused by malnutrition.	Initiate bowel program to bulk stools if no medical contraindication. Encourage patients to order foods such as cereals and grains, multigrain breads. Beans, cooked lentils, fruits, pears avocado, raspberries, banana, almonds, peanuts, vegetables such as green peas, vegetable soup, cooked broccoli, carrots.	This will decrease the possibility of the patient having MASD, perianal excoriation and pressure ulcers. Also gives the patient the possibility to utilize a bed pan.
Impaired skin integrity evidence by intact, blanchable, erythema to perineal area.	Cleanse area with pH balanced cleanser and pat the skin dry. Continue external urinary catheter and continue connection to gravity drainage. External urinary catheter change: Remove the external urinary catheter daily and replace with a new one: remove by wrap penis with warm wash cloth for approximately 1-2 minutes. Gently roll the catheter down the shaft of the penis avoiding pulling on the catheter tubing. Cleanse the penis with soap and water to remove the adhesive or utilize adhesive remover if necessary. Reapply the external catheter: Inspect the skin to ensure the skin is intact and free of inflammation. Then: select the appropriate size catheter, apply liquid barrier skin protectant to the penile skin and allow it to dry. Apply the external catheter by gently rolling the condom catheter down the shaft of the penis. External fecal pouch change: Remove external fecal pouch every 1-2 days and as needed for leakage. Disconnect the spout from the drainage bag and close the cap, then gently	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. Repositioning decreases the risk for pressure injury by redistributing the pressure to different parts of the body. It also removes the pressure off the bony prominences each time the patient is repositioned.

	peel the pouch from the skin by the push pull method and remove the pouch. Reapply the external fecal pouch: Inspect the skin for breakage or inflammation, then peel the backing off the pouch and place it to the anal opening, the tube of the pouch should be already connected to the collection bag which should be positioned below the patients buttocks. Secure the collection bag to the bag such like a foley bag. Continue pressure redistribution measures, reposition patient every two hours; utilize slide sheets to reposition, optimize pressure relief over the bony prominences and float the heels as best possible.	

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.** 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. 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 are soft pads that are ingrained with superabsorbent beads. 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.

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 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. I also learned if the external fecal pouch is leaking, must remove the system, cleanse the area and reapply a new pouching system. 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. Recommend avoiding fried fatty foods and artificial sweeteners. Please ensure patient is adequately hydrating through the day with at least 64 ounces of fluid in 24 hours. Dietician consult for review of diet, to ensure fiber enriched diet is ordered.
What are your learning	To continue to learn more detail in the continence world.

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goals for tomorrow? **(Share learning goal with preceptor)**	

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	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.

Reviewed by: _____ Date: _____

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