

Daily Journal Entry with Plan of Care & Chart Note

 Student Name: _____ Joe Gersna _____ Journal Completion Date: 3/2/203

 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.

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.
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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 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
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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. Check patient hourly for leakage around external FMS and condom catheter. If leakage occurs	Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.

(Save the document by clinical date & preceptor last name before submitting to your dropbox each clinical day)

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<p>Risk for impaired skin integrity due to urinary and fecal incontinence.</p> <p>At risk for electrolyte imbalance and nutritional deficits due to decreased PO intake and history of diabetes. <i>NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc</i></p>	<p>replace the system and check for skin breakdown where it has occurred.</p> <p>Start a bulk forming bowel program to include a high fiber diet.</p> <p>Avoid the use of briefs and undergarments you are is immobile. Briefs and undergarments can be used while mobile or in the chair.</p> <p>Utilize a reactive support pressure redistribution mattress to minimize pressure injuries. Turn the patient at Q2H intervals.</p> <p>Monitor patient blood glucose ACHS. Blood sugar levels above 180 can be managed with insulin while inpatient.</p> <p>Utilize an incontinence pad underneath patient in a single layer to absorb excess moisture.</p> <p>Use a PH balanced cleanser and moisture barrier cream after each incontinent episode.</p>	<p>An external FMS and condom catheter are appropriate while the patient is incontinent and with limited mobility. The seal on both devices adheres to the skin and can cause breakdown if stool or urine becomes trapped in between the barrier. When the patient begins to form more solid stool consider discontinuation of the device.</p> <p>A high fiber diet can solidify stool with foods such as wheats, whole grains, beans, and apples. Liquid stool contains irritants that can cause skin breakdown.</p> <p>Briefs and undergarments retain moisture when saturated with urine and will cause skin damage. This patient arrived without being changed from the nursing home.</p> <p>Pressure redistribution surfaces respond to the patients body and will absorb pressure off of bony areas. As this patient is immobile with limited movement he will require frequent offloading to minimize injury risk.</p> <p>A patient with a history of diabetes, high blood sugar can impair skin healing and place patients at higher risk for wounds.</p> <p>An incontinence pad will help absorb moisture from leakage and wick it away from the patient skin. A single layer prevents friction injury from shearing forces. A blue underpad does not have absorptive properties.</p> <p>A PH balanced cleanser or soap and water can be used after incontinent episodes to cleanse the skin, and a moisture barrier cream to protect from stool and urine.</p>
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<p>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?</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <p>An external FMS is used for this patient. These devices are non-invasive and contain the stool and prevent it's spread to linen and other areas of skin. Downsides of this product include frequent changes of every 1 to 2 days, requires more than one caregiver to apply, and stool can seep in between the barrier if not changed at timely intervals. An alternative an internal fecal management system can be used. These can last up to 30 days but can be uncomfortable and cause damage to the internal sphincter.</p> <p>An external male condom catheter is used as a collection device for urine. These are adhesive and require a proper fit to prevent leakage. An improper fit can cause skin damage and leak urine. This device requires changing every one to two days which can become costly for extended hospitalization. The other alternative that is in use is absorbent pads underneath. The blue bad does not have an absorptive feature, so a washable or reusable pad with maximum absorptive properties would be best. This will wick away moisture and prevent pooling underneath the patient. An example available is the ExtraSorb Dry pads. This will require more frequent patient monitoring and linen change than an external catheter.</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.

<p>What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?</p>	<p>This case study reflects an immobile patient who suffers from two forms of incontinence. The goal is to manage both while maintaining patient dignity. The goal was to formulate a plan that protects the patient while provides a path to improving fecal incontinence. A multi-faceted approach to address pressure injury risk and skin breakdown from incontinence was necessary. The recommendations in place should help this patient remain injury free while hospitalized.</p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>In a clinical setting I would use this opportunity to practice replacing external fecal and urine management systems while preserving patient dignity. Goals are to ensure a proper fit and seal are placed with each and minimize drainage to the underlying linen.</p>

<p>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>Fecal management systems and external condom catheters can affect a patient's dignity. Looking for opportunities to improve bowel health and reduce diarrhea should be a priority for removing the FMS system. I would change the blue underpad recommendation to a more absorbent product if the external condom catheter is removed.</p>
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Reviewed by: _____ Date: _____

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