Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Romeo Journal Completion Date: 3/4/23

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. Fecal incontinence as evidenced by oozing liquid stool Incontinence associated dermatitis related to urinary and fecal incontinence Secondary fungal infection as evidenced by satellite lesions. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions:***	**Statements should be directive and holistic relating to the problem/concern.** -Continue use of internal fecal management system while incontinent of liquid stool. Application of FMS: -Turn patient on left side in knee chest position -Cleanse perianal skin with periwipes. Let dry. -Insert lubricated balloon end of device into the rectum and inflate balloon. -Connect to drainage bag. - Position collection bag below the level of the buttocks, avoiding kinks. Secure collection bag to bed. -Discontinue use of internal fecal management system after 29 consecutive days. -Notify WOC nurse if leaking of stool is noted	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** -Internal fecal management systems can be used to protect the perianal skin from frequent liquid stools (Callan & Francis, 2022). As this patient is frequently incontinent of liquid stool and the perianal/perineal skin is showing signs of irritation and skin breakdown, an internal bowel management device is appropriate as long as it is not contraindicated. An internal bowel management device should not be

knowledge deficit, fluid/electrolyte imbalance, etc	surrounding internal fecal management system. -Clean inner thighs and perineal skin with no-rinse peri cleanser after each incontinent episode or use of bedpan. -Twice daily, apply critic aid clear AF skin barrier to inner thighs and perineal skin. -Do not use briefs unless patient is ambulating. Remove brief when back in bed. -Minimize layers under patient. Use only one bed sheet, one draw sheet and one absorbent pad. -Use mechanical lift only for moving patient up in bed. Do not move patient up in bed using the draw sheet. -To place of remove bedpan, roll patient only. Do not slide bedpan under patient.	used on a patient with clotting disorders or confirmed injury to the anus and/or rectum. If the patient is known to have anal or rectal stenosis, stricture, tumor, hemorrhoids or fecal impaction, the device is contraindicated. It should not be used on patients who have had rectal or large bowel surgery within the last year or if the patient has an impairment of the rectal mucosa such as ulcerations, proctitis or ischemic proctitis. An internal bowel management device is also contraindicated if the patient has any other device in place in the rectum or anus or is receiving enemas. -Instructions regarding placement of the internal fecal management system may vary with different manufacturers so it is important to read the instructions carefully prior to applying. -Placing the patient in the side lying knee chest position will help to expose the perineal area. -Prior to placing the FMS, the perianal skin should be cleansed of stool and the rectum should be free of solid stool. The WOC nurse should perform a digital examination to determine if there is any solid stool in the rectum and if the patient has adequate rectal tone. Adequate rectal tone is needed to keep the balloon in place. The FMS is kept in place by inflating the balloon once the device is placed in the rectum. -The collection bag will contain the stool. It should be below the level of the buttocks to facilitate drainage of the stool into the bag. The collection bag should be secured to the bed. This will help to prevent accidental or traumatic removal/pulling of the tube. -The nurse should be aware of the duration the device has been in place. The necessity of the device should be considered daily (Callan

		& Francis, 2022). If the device is no longer a necessity, it should be removed as soon as possible. These devices should not be used if the patient has chronic diarrhea as they are only intended for short term use and should not stay in place for longer than twenty nine days in a row. -If stool is leaking around the FMS, onto the skin, it can lead to perianal skin breakdown. If leaking is noted, the system should be assessed as soon as possible. -A skin care regimen should be implemented immediately. This will consist of cleansing and protecting the skin (Thayer & Nix, 2022). The skin should be cleansed immediately after every episode of incontinence. A pH balanced cleanser, such as no rinse peri cleanser should be utilized. If pH balanced cleanser is not available, water can be used, rather than soap. Bath soaps can contribute to increased irritation of the affected area, so they should be avoided. To effectively protect the affected area, a waterproof moisture barrier should be applied. This will help to repel the moisture from the skin. Critic aid clear AF skin barrier is a clear, antifungal moisture barrier. Satellite lesions were noted, indicative of a fungal infection, so this is an appropriate choice for this patient. According to manufacturer directions, it should be applied one to two times per day. -If not changed immediately after incontinence episode, briefs can trap heat and moisture and cause the existing skin damage to deteriorate. Overhydrated skin is more vulnerable to skin damage as the stratum corneum is affected, potentially leading to inflammation and irritant dermatitis (Thayer et al., 2022). The brief may also put tension on the FMS, increasing the risk of a device related pressure

		injury. It is appropriate for the patient to wear a brief when ambulating so any episodes of incontinence will be contained. -Multiple layers of bed linens can increase the risk of developing skin damage from friction as well as trap moisture and heat against the skin, making the skin more susceptible to skin damage (Borchert, 2022). When the skin is overhydrated, it is less resilient to friction, shear, and pressure. The absorbent pad is designed to wick moisture away from the skin and will help to prevent skin damage related to pressure and moisture. -Ensuring that the patient is lifted via a mechanical lift when moving the patient up in bed will minimize the risk of the patient developing skin damage from friction and shearing. This will ensure the patient is lifted and not dragged up in the bed. -Ensuring that the patient rolls to place the bedpan will help minimize friction that may occur if the bedpan is placed by having the patient lift their hips. This will also protect the FMS, which could become dislodged or traumatically removed by sliding a bedpan under the patient.

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.** -Internal fecal management system-Disadvantage: many contraindications to use, invasive. Alternative: external fecal pouch -Peri wipes-Disadvantage- can cause friction when wiping. Alternative- clean skin with water using a syringe -No rinse peri cleaner-Disadvantage: patient may have sensitivity or allergy to ingredients. Alternative: water Critic care clear AF skin barrier- Disadvantage: can only be applied twice daily per manufacturer. Alternative: crusting method using nystatin powder and Cavilon skin barrier; apply a thick coat of Desitin after every episode of incontinence. Absorbent pad- Disadvantage: one time use, more costly. Alternative: washable/reusable underpad

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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 was to learn more about ways to prevent moisture and incontinence associated skin damage. I met my goal.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to learn more about treatment for stress urinary incontinence.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	-As the internal FMS is more invasive and there is more risk involved, I would have trialed an external fecal management device first. -I wound recommend a physical therapy consult -If the patient is able to ambulate with assist, I would recommend initiating a timed voiding toileting program. -I would evaluate the necessity for the lactulose daily as the hepatic encephalopathy improves. -Consider a stool culture to rule out infectious diarrhea.

Reviewed by: _____ Date: _____

References

Borchert, K. (2022). Pressure injury prevention: Implementing and maintaining a successful plan and program. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 396-424). Wolters Kluwer.

Callan, L., & Francis, K. (2022). Fecal incontinence: Pathology, assessment, and management. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 484-519). Wolters Kluwer.

Thayer, D., & Nix, D. (2022). Incontinence-associated dermatitis. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 364-381). Wolters Kluwer.

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Thayer, D., Rozenboom, B. J., & LeBlanc, K. (2022). Prevention and management of moisture-associated skin damage (MASD), medical adhesive-related skin injury (MARSI), and skin tears. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 323-354). Wolters Kluwer.

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