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:** 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 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

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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. Fecal incontinence as evidenced by oozing liquid stool Incontinence associated dermatitis related to urinary and fecal incontinence ***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.** -Change external fecal pouch every 1-2 days or if leaking. Notify WOC nurse if perianal skin breakdown is noted or if unable to maintain seal of fecal pouch for re-evaluation. To remove pouch: -Remove appliance using push pull technique. To apply pouch: -Clean perianal skin with pH balanced cleanser. Pat dry. Remove paper backing from the pouch to expose adhesive. Apply the pouch over the opening of the anus. Attach tube from pouch to collection bag. Position collection bag below the level of the buttocks. Secure collection bag to bed. Incontinence associated dermatitis: -Appy a thick layer of Desitin to affected area as needed. Initiate toileting program for timed voiding: -Assist patient to use the toilet/bedside commode first thing after waking, before meals, after meals and at bedtime. Toilet patient every 2 to 4 hours if she wakes overnight. As the WOC specialty nurse What caused the wound and what are you going to do with the wound? And the bigger picture related to the wound?	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** -The external fecal pouch should be changed every 1-2 days (Callan & Francis, 2022). If stool is leaking onto the skin, it can lead to perianal skin breakdown. If leaking is noted, the system should be replaced as soon as possible. -The push pull technique can help to protect the perianal skin from traumatic damage during pouch removal. -The skin should be cleansed with a pH balanced cleanser prior to application. This will help to remove oils from the stool that are present on the skin. If oils remain on the skin, the pouch may not adhere well. The pouch should be applied over the anus to collect the stool. 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. -To effectively protect the affected area, a waterproof moisture barrier should be applied (Thayer & Nix, 2022). This will help to repel the moisture from the skin.

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		This cream should be applied in a thick layer after every incontinence episode or as needed. -The timed voiding toileting schedule is appropriate for this patient as she has cognitive impairment related to a recent CVA. She is able to get out of bed with a 2-person assist. To be a candidate for a timed voiding regimen, the patient must be cooperative and agreeable to toileting, able to use the toilet with assistance, and able to void when toileted (Thompson, 2022). This program is appropriate for patients who are not aware or unable to communicate the need to void or defecate.

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.** -External fecal collection pouch-Disadvantage: intended only for non-ambulatory patients, unable to perform rectal exams or administer rectal medication. Alternative: Strict skin care regimen consisting of cleansing and protecting the skin as an internal fecal management system is contraindicated for this patient at this time. -Desitin-Disadvantage: adhesive will not stick this/may compromise the seal of the external fecal pouch. Alternative: Cavilon skin barrier or Marathon

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 toileting programs. I met my goal as I read about the different toileting programs and what types of individuals are good candidates for each of them.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to learn more about the various support surfaces.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	-This patient is on both lactulose and rifaximin. I would inquire as to why she is on lactulose as this medication can be administered for reasons other than constipation. I would question if this medication is necessary as it is likely contributing to the continuous liquid stool. I would also inquire as to why she is taking rifaximin. This medication is typically given for treatment of traveler's diarrhea and irritable bowel

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	syndrome with diarrhea. I would want to know the history/etiology of the diarrhea, if possible. -Patient is on heparin so she is not a candidate for internal fecal system due to the increased risk of bleeding. I didn't include detailed instructions for cleaning for the IAD because the patient has a fecal pouch. Assuming that this works correctly, stool shouldn't be leaking onto the skin, so Desitin can just be applied as needed over affected area. PT consult due to deconditioning from the CVA Correction 3/7/23: As the patient was found unresponsive for an unknown amount of time, it is possible that this wound is a pressure injury. As there is tissue loss and the wound base is visible and red, it is likely a stage 2 pressure injury at this time. The periwound maceration indicates the periwound skin is overhydrated. The patient has a Braden score of 15 and is currently at mild risk for pressure injuries. I would recommend a support surface for this patient, which she is already on. I would implement a turn schedule and measures for moisture management. Plan: Continue first step mattress with only one bedsheet, one drawsheet and one absorbent pad. Reposition patient every 2 hours-left and right only, no supine positioning. Ensure patient is not laying on tubing from external fecal system. Keep HOB < 30 degrees except at mealtime to decrease risk of shearing injury. Apply Cavilon skin barrier to periwound skin and cover with a sacral mepilex dressing. If moderate to large amount of wound drainage, cover with Aquacel and sacral mepilex dressing. Change dressing every three days or as needed.

Reviewed by: Patricia A. Slachta Date: 3/7/23

References

Callan, L. 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.

Thompson, D. (2022). Management fundamentals for incontinence. In J. M. Ermer-Seltun & S. Engberg

(Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 83-110). Wolters Kluwer.

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