Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Janet Barylski_____ Journal Completion Date: _7/26/2023_____

Setting: __X___ Acute Care _____ Outpatient _____ HHC ____ Other _____
Continence-8

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	84-year-old male with a past medical history significant for depression, hypertension, dyslipidemia, motor vehicle accident resulting in right above the knee amputation and suprapubic catheter, TIA, cataracts, and dementia. The patient was admitted to the hospital for multi-drug resistant infections both to the sacral stage IV pressure injury and ESBL in the urine. The patient is a poor historian. The patient is known to the outpatient clinic and was seen prior to admission for negative pressure wound therapy. It was noticed that the wound was stalled, malodorous, and exhibited increased drainage. The LIP obtained a culture which indicated polymicrobial growth. Around the same time frame, the patient was seen by PCP and a urine culture was taken which grew a resistant organism. The patient was admitted for IV antibiotics and wound care. This is hospital day #4. **Surgical history:** Above the knee amputation s/p MVA 2014 Suprabupic catheter s/p MVA 2014 Left knee replacement 2011 **Medications:** Vancomycin 1 Gm IV q 18 hours Unasyn IVPB 100 mg IV q 6 hours Heparin flush 20 units IV prior to discharge x 1 All other PO medications are on hold at this time (acetaminophen, lisinopril, and rosuvastatin until swallow study can be completed) **Social hx:** Smoking: never smoked ETOH: none Illicit drug use: none **Diagnostics:** Urine Culture: + E. coli, and ESBL Blood culture: negative Wound culture: +S. aureus, S.anginosus, Diphtheroids CT Pelvis w IV contrast. Report Findings: Sacral decubitus ulcer with ulceration of the underlying distal sacrum and coccyx. No evidence of focal fluid collections to suggest abscess.

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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.

CWOCN-AP NOTE

Follow-up visit for suprapubic catheter care

Subjective:
ROS: unable to obtain at this time. 84 y/o male poor historian.

Objective:
T: 98.9ºF, HR 70 regular, RR 18 regular, BP 138/84

General: Well-nourished, well-developed male, who appears stated age. No distress noted. Awake, confused, non-verbal, oriented to name only.
HENT: Normocephalic, atraumatic, moist oral mucosa, no nasal drainage, no visible lesions on external ears or nose, no oral lesions
Resp: No accessory muscle use or increased work of breathing. Respirations even and unlabored, clear to auscultation.
CVS: Heart sounds are normal with a normal apical impulse. No murmurs, gallops or rubs
PVS: right AKA, BLE warm, appropriate for ethnicity, R popliteal pulse 1+, L pedal, 2+, L popliteal pulse 1+, No edema noted
ABD: Abdomen soft and round. Active bowel sounds x 4 quadrants.
GU: suprapubic urinary catheter, unsecured to skin, draining clear yellow urine.
MSK: Well-healed right AKA stump noted. No visible effusion, swelling, increased warmth, erythema, or limitation of motion of major joints.
Skin: Stage IV pressure injury to sacrum. NPWT device intact to site. PICC line right upper arm. Red rash around suprapubic catheter site, no satellite lesions.

Assessment:
Suprapubic catheter, periostomal skin breakdown
Dementia
Chronic wound, stage IV pressure injury sacrum with polymicrobial growth being managed by PCP

Plan:
Swallow study to be completed as ordered, if patient is unable to take PO intake, then referral to Pharmacy for hyperalimentation dosing.
Referral to registered dietician for dietary support.
Continue low air loss mattress and turn patient every 2 hours
Continue antibiotics per ID
Secure urinary catheter with medical adhesive tape or with a commercial device; prevent dependent loops of drainage; measure I/O every 8 hours
Local skin care to suprapubic site
Monitor the patient for fecal incontinence and diarrhea while on IV antibiotics.

Patient education:
Patient unreceptive to teaching at this time

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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. ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc*** Urinary tract infection AEB UA/CS due to presence on indwelling urinary catheter Impaired skin integrity AEB red rash without satellite lesions due to incontinence associated dermatitis	**Statements should be directive and holistic relating to the problem/concern.** 1) Prevention of Complications: - Aseptic technique - Position drainage bag below bladder using drain hook to keep it off the floor - Label bag with insertion information: initials of person who inserted, Date, time, size of catheter and balloon - Label any collection canisters (ie: graduated cylinder) with patient name, date, and type of fluid - Tube free of kinks, avoiding dependent tube loops - Empty collection bag if >400mLs im bag; avoid splashing - Use needleless sampling port for urine collection - Use systems with tamper-resistant seal to maintain closed system - Using an anchor/securement device, secure catheter at the bifurcation - Cover stoma site with fenestrated gauze 2) ABCDE of CAUTI prevention - **A**dhere to infection control, supplies, procedures, & processes - Hand hygiene - Aseptic insertion - Proper foley care - Monitoring - **B**ladder ultrasound to avoid improper / unnecessary use of catheters - **C**atheter alternatives - intermittent catheterization instead of indwelling catheterization - condom catheter for med - absorbent pads and products for incontinence - **D**o not use catheter for inappropriate medical indications - **E**arly removal of the catheter by using "stop orders" and reminders 3) Use approved commercially prepared moisture barriers ointment - after initial cleaning and after each leakage	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** 1) - decreases risk of infection - facilitates urine drainage and prevents backflow of urine. ~~Keep the bag off the floor to decrease contamination of the bag & drain spout.~~ - communicates when catheter was placed to determine when it should be changed - labeling canisters prevents cross contamination - intraluminal bacteria are transmitted through the entire length of the closed system due to urinary stasis. No kinks or dependent loops allows urine to flow all the way to the collection bag. Dependent loops may also increase bladder pressure, increasing the transit time of urine through the drainage tubing. - A catheter drainage bag should not be emptied more often than necessary as this increases the risk of infection. However, the bag must be emptied before it becomes completely full, e.g. 2/3rds full, to avoid back flow of urine into the bladder. Prevent splash back because antibiotic resistant infections (such as VRE) can be spread. - breaking the system introduces more bacteria into the intraluminal system. The tamper-resistant seal and use of sampling port prevent breaking the closed system. - increased manipulation of the catheter can cause migration of bacteria extraluminally and is associated with increased incidents of CAUTI.

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	(incontinence) episode - Use perineal cleanser or disposable wipe to gently remove ointment once daily to assess skin. NOTE it is not otherwise necessary to wipe away all the ointment. Other than the 1x complete removal of ointment, it is only necessary to wipe away only the soiled ointment. NOTE if it is difficult for patients to perform these multiple steps, patient can use a 3-in-one wipe.	- fenestrated gauze provides an absorptive barrier between the stoma and the environment to diminish exposer to pathogens. It will also aid in keeping the peristomal skin dry, decreasing the IAD. 3) The ointment will provide both moisture and chemical irritants. 2) -A: breaching infection control increases the already high risk of UTIs. Hand hygiene is the #1 method to prevent spread of infection. Aseptic technique decreases introduction of bacteria to catheter system. People who have their catheters inserted in OR have less occurrence of infection. He has e-coli in his UA/CS. One way to avoid this is hand washing. ~~Proper foley care (cleaning the foley away from the entry point) impeded bacteria entry via insertion site.~~ -B: ensures patient is experiencing urinary retention -C: use external methods to manage continence whenever possible to avoid a pathway for bacteria to enter the body (via indwelling). Intermittent catheterization impedes colonization and biofilm secondary to leaving the catheter in. -D: Prevents unnecessary complications associated with catheters -E: long term use of catheters over 30 days is associated with serious complications such as bladder calculi, urinary leakage, and increased risk of squamous cell bladder cancer. ~~UTIs occur in 31% of long-term catheter placement. Colonization develops within a few days. Specific to SPC are skin irritation at stoma, dislodgment, and track closure. Reminders are helpful to all staff and create continuity of care to determine necessity of~~

		~~catheter and reduce CAUTI.~~ 3) Excessive wiping off of the ointment (which can be difficult to remove due to presence of Zinc) can add unnecessary trauma to the skin. ~~Note that this patient has dementia and diminished vision. He may need SNF placement if he does not have an at home caregiver. His dexterity should also be evaluated to see if he can perform his hygiene adequately.~~ Good thinking in this section & these are things you would put at end Thank you. Funny thing is that I always thought this way about Calmoseptine (ohhh how people love to use it in the field) and educated them about traumatic skin cleansing back then before I even knew about it. May I ask you something? I have not heard anything on this technique and forgot to ask in clinical…but there were times that I also used to educate people on wiping toward the center of the wound to avoid undue tension and pulling apart on the skin because it was making some wounds worse.

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.** - Convatec Critic-Aid Clear Skin Protectant Cream will provide a moisture barrier to the urine to prevent skin irritation. This product contains petroleum and zinc. However, it only contains an inactive amount of Zinc. A barrier cream with a higher amount of Zinc may be more effective. You could also use Domeboro astringent solution to cleanse the skin. Follow package directions. - Aloe Vesta Perineal and Skin Cleanser is a pH balanced skin cleanser. If it is not available, warm water is acceptable. Soap is not pH balanced and can cause skin irritation with IAD.

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	My goal was to see patients with continence related issues for my daily journal. My goal was not met due to the needs of patients on the visit list.

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meet your learning goal for today? Why or why not?	
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	To continue to work on continence relates issues for my journals and see and do clinical actions I have not done.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc **Please answer this section & resubmit- consider what I had at end of rationale + is there anything else?**	Keep the bag off the floor to decrease contamination of the bag & drain spout. antibiotic resistant infections can be spread even if they are in the urine. He has drug resistant infections. Where are the contact precautions? S Aureus is MRSA. Private room? There are signs of hygiene issues. He has e-coli in his UA/CS. One way to avoid this is hand washing. MRSA. He is getting intestinal flora in his urine when he has a SP catheter. Diptheroids…. Mucous membranes. I can't help but think he is getting his hands into everything and not washing them. Touch here and touch there… everything is spreading. NPWT should not be off for more than 2h. This was not addressed either. It has been at least 5 days since he was seen in the clinic. No wonder he has an infection. Maybe it hasn't come up to scream here I am, but just because he has dementia does not mean he needs a swallow study. He is normal weight, etc. Was there a CXR or something? What is the indication? Infection control measures need to be taught. Proper foley care (cleaning the foley away from the entry point) impeded bacteria entry via insertion site. UTIs occur in 31% of long-term catheter placement. Colonization develops within a few days. Specific to SPC are skin irritation at stoma, dislodgment, and track closure. Reminders are helpful to all staff and create continuity of care to determine necessity of catheter and reduce CAUTI. Note that this patient has dementia and diminished vision. He may need SNF placement if he does not have an at home caregiver. His dexterity should also be evaluated to see if he can perform his hygiene adequately. Female – POD 2, removed rod, provided 1st teaching for pouching Female – BCIR with no to small amount of output. Flush, insert catheter, and connect to gravity drainage. Discuss any s/s of obstruction. Female with establishes urostomy who also received an ileleal conduit due to bladder cancer. Had hernia repaired. Re-pouched. Male – refused pouch change. Was experiencing leaking secondary to poor stoma placement r/t emergent surgery. Participated in verbal lesson of post-op #2 session for pouching. Female – end ileostomy. Hernia. Mucous fistula. Repouch. Getting d/c to SNF.

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Reviewed by: Patricia A. Slachta__ Date: PAS

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