Cleveland Clinic

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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _Bessann M. Muuo-Wambua Journal Completion Date: 7/25/2023___

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:** 76-year-old female is being seen with the admitting diagnosis of Failure to thrive in adult [R62.7], Fecal impaction in rectum (HCC) [K56.41] being managed by primary team. Patient last seen by WCCT on 7/5/23 where she did not have a pressure injury but IAD to the groin and MASD to the coccyx. WCCT consulted for a potential pressure injury to the coccyx, upon assessment IAD to the groin and extending down bilateral medial thighs, area is denuded and painful for the patient with cleansing. Coccyx with IAD and MASD to the perineum, no pressure injury noted at this time. Area is denuded but very dry, will stop the CCF paste and Desitin to the coccyx and switch to Critic-Aid Clear, Desitin still to be applied around FMS. Patient c/o moderate pain with cleansing. **Chief Complaint:** "It is very painful" **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.

Reason for Consult: Potential pressure injury to the coccyx

Review of Systems:
PAIN ASSESSMENT: Currently having pain; Location/Distribution: Moderate pain to the coccyx with cleansing
GENERAL: No weight loss, malaise or fevers

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RESPIRATORY: Negative for cough, SOB or dyspnea
GI: Negative for nausea, vomiting and Positive for fecal incontinence FMS to GD
GU: Negative for dysuria and frequency and Positive for incontinence
SKIN: Negative for lesions, rash and itching. See wound documentation

Objective
PHYSICAL EXAM:
BP 119/65| Pulse 95| Temp (Src) 97.9 (oral)| Resp 19| Ht 5'0" (1.52m)|Wt 114 lb 3.2oz (51.8kg)| Sp02 94%| BMI 22.30kg/(m^2).

PHYSICAL EXAMINATION:
General appearance: Alert, in no acute distress, pleasant and cooperative
Skin: Skin color, texture, turgor normal, no suspicious rashes or lesions, wounds (see below)
Braden score: 17
Musculoskeletal: 2 assist with turns in bed
Neuro: Oriented x's 3
GI: Incontinent of liquid brown stool, FMS to GD
GU: Incontinence of urine, female external to wall suction

Presenting wound information:
Wound 03/28/2023 1223 Incontinence Associated Dermatitis Coccyx (Active)

Impression/Recommendations
Impression
-Coccyx – IAD
-Groin extending down medial thighs-IAD
-Perineum – MASD

Recommendations
Plan
-Coccyx & Groin – Apply Critic-aid Clear to coccyx extending onto bilateral buttocks, groin and medial thighs BID and as needed.

Prevention
Bilateral Heels- Apply Sensicare No-Sting barrier wand daily.
Maintain Tru-Vue heel protectors to bilateral lower extremities, to off-load heels, while in bed.
Maintain turning and positioning system to off-load patient's coccyx/ischium every 2 hours.
WCCT will continue to follow patient. Please reconsult if wounds worsen.

Barriers to Healing: Body habitus, Comorbid conditions, Mobility, and Moisture
Pressure Injury Prevention: Heel offloading, Low air loss surface, Moisture Engagement, Turn schedule and Turning positioner/wedge

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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
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)**
Moisture-Associated Skin Damage (MASD) across coccyx, groin, medial thighs, and perineum due to moisture and incontinence.	1. Keep a Close Eye on Your Skin: • Make it a habit to examine your skin every day, paying special attention to your coccyx (tailbone), groin, and perineum (genital area). • Notice the color, texture, and any redness, raw areas, or discomfort you might feel. 2. Handling Moisture for Healthy Skin: • Apply Critic-Aid Clear skin barrier to areas like your coccyx, groin, and medial thighs twice a day or as needed. This helps create a protective layer. • Use the Flexi-Seal FMS (Fecal Management System) to manage any liquid stool, preventing more damage from moisture. • Watch out for any stool leaking around the FMS, and let your healthcare team know if it's happening a lot. • After using the bedpan or if there's any episode of incontinence, gently clean the reddened areas with a no-rinse peri-cleanser. 3. Preventing Sores and Pressure Injuries: • Change your position regularly, every 2 hours, to take the pressure off your coccyx and ischium (pelvic bone). • When you're in bed, use Tru-Vue heel protectors to protect your heels from	• Regular assessment and documentation of the skin's condition provide a baseline for evaluating the effectiveness of interventions and identifying changes that require attention. • Applying Critic-Aid Clear skin barrier helps protect denuded skin from further moisture damage and supports healing. Flexi-Seal FMS assists in managing liquid stool, reducing the risk of skin breakdown. • Frequent turning and repositioning prevent prolonged pressure on vulnerable areas,

	getting sore. • Your care team will apply Sensicare No-Sting barrier wand on your heels daily. This helps prevent injuries from pressure. • Your mattress might be replaced with a special low air loss surface that helps spread out pressure and reduces the risk of pressure injuries. 4. Learn and Share Skin Health: • Understand and discuss with your care team why it's important to keep your skin clean and dry. This helps prevent more skin damage.	reducing the risk of pressure injuries. Tru-Vue heel protectors and Sensicare No-Sting barrier wand provide additional protection to high-risk areas. • Patient and caregiver education promotes awareness and active participation in skin care, contributing to better outcomes.

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?	• **Critic-Aid Clear skin barrier** Disadvantage - May require frequent reapplication, especially in areas prone to moisture. Alternative - Cavilon No Sting Barrier Film, which also provides a protective barrier against moisture and friction. • **Flexi-Seal FMS** Disadvantage-A disadvantage could be the potential for discomfort or irritation due to the presence of the device. Alternative - Regular assessment and management of liquid stool without the use of a specialized FMS. • **Sensicare No-Sting barrier wand** Disadvantage - May not be suitable for patients with allergies to its components. Alternative - Calmoseptine Ointment, which provides a protective barrier and has soothing properties.

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	The goal for this mini case study was to gain a deeper understanding of managing moisture-associated skin damage and pressure injury prevention. I believe I was able

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meet your learning goal for today? Why or why not?	to achieve my learning goal for today. My goal was to integrate pain management strategies into the plan for addressing the multi-focal skin damage, specifically Moisture-Associated Skin Damage (MASD). By incorporating prescribed pain medications and alternative techniques like positioning changes and distraction methods, I aimed to enhance patient comfort during skin care procedures. I successfully integrated these strategies into the plan, ensuring that the patient's pain is managed effectively while addressing their skin damage. This experience has deepened my understanding of the importance of considering pain relief as an integral part of wound care and patient well-being. I also learned how to incorporate specialized products like Flexi-Seal FMS into a plan of care for patients at risk of moisture-related skin damage.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	Explore the use of alternative pressure injury prevention strategies and products to broaden my knowledge.

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This case study highlighted the importance of assessing and managing moisture-associated skin damage, as well as preventing pressure injuries. It's clear that a holistic approach, including regular assessment, proper positioning, and the use of appropriate products, is essential for patient care. I would have considered further exploring the patient's medical history and medication regimen to identify potential contributing factors. I was able to meet my learning goal for today by integrating the use of Flexi-Seal FMS into the plan of care. Tomorrow, I aim to expand my knowledge on alternative pressure injury prevention strategies and products.

Reviewed by: _____ Date: _____

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