

Daily Journal Entry with Plan of Care & Chart Note

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 Journal Completion Date: 11/17/23

 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	<p>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 bilirubin 2.9. CT and MRI head negative for stroke. Altered mental status likely due to hepatic encephalopathy and patient started on lactulose and rifaximin.</p> <p>Surgical history: No surgical history on file, patient confused and unable to give accurate history.</p> <p>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</p>
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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 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)
<p>Identify specific problems or concerns. “Risk” concerns should be incorporated into the plan for actual problems/concerns.</p> <p><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>Statements should be directive and holistic relating to the problem/concern.</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p>
<p>Urinary Incontinence</p>	<p>Cleanse perineal area after each incontinence episode with a pH balanced cleanser and gentle wipes.</p> <p>Do not use wash clothes.</p>	<p>A pH balanced cleanser will be gentle on the skin in removing irritants. The use of wipes is also gentle to the skin.</p> <p>Wash clothes should not be used on denuded skin due to the rough</p>

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	<p>Pat dry the red, denuded area prior to applying the Critic Aid Clear AF skin barrier.</p> <p>Apply Critic Aid Clear AF skin barrier as needed to redden areas.</p> <p>Use one absorbent pad under patient. Only use a brief or pull up when patient is out of bed.</p>	<p>material that can exacerbate the breakdown.</p> <p>The skin should be dry from the cleanser and moisture used for cleansing to prevent moisture help against the skin by the skin barrier. Excessive moisture held to the skin can worsen the breakdown present.</p> <p>If the patient is frequently incontinent, then multiple cleansing of the perineal area can remove the skin barrier. The skin barrier should be applied as needed when it is removed or soiled.</p> <p>Multiple absorbent pads under a patient can hold moisture against the skin like briefs or pull ups.</p>
<p>Fecal Incontinence</p>	<p>Assess FMS with each repositioning.</p> <p>Document any leakage from FMS.</p> <p>Consult WOC for excessive leakage form FMS.</p>	<p>Frequent reassessing of FMS placement when patient is repositioned helps monitor for leakage or dislodgment.</p> <p>Documentation of leakage amount and when it occurs can help the nursing staff and WOC RN in reassessment.</p> <p>If the leakage is excessive, then the FMS has failed and needs reassessment from the WOC team.</p>

<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>Critic Aid Clear AF skin barrier- This skin barrier is for fungal infections and to create a barrier from excessive moisture and irritants. The skin barrier can hold moisture against the skin if it is not properly cleansed and dried. This can cause further skin breakdown. Another alternative to use is a Nystatin powder.</p> <p>FMS-This fecal management system can have excessive leakage if the patient’s anal tone is not sufficient or placed properly. Another alternative is an external fecal collection pouch. This is a noninvasive alternative that does not put the sphincters or rectal tissue at risk for damage. It also protects the perianal skin from breakdown.</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.

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<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>I chose this mini case study to learn more about continence care and fecal management systems. I believe I met my learning goal. I understand the use of the FMS and the different products that can be used for the denude skin to the patient's thighs and perineal area. Urine and stool irritants can cause rapid skin breakdown if not removed immediately or treated.</p>
<p>What are your learning goals for tomorrow? (Share learning goal with preceptor)</p>	<p>N/A. See next continence virtual journal.</p>

<p>Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc.</p>	<p>This was an interesting mini case scenario. The thing I would do differently is to utilize an external female urinary catheter. The use of the external catheter would help prevent urine irritants from the skin and keep the thighs and perineal area dry. The Critic Aid Clear AF skin barrier is an appropriate treatment for the red denuded skin with satellite lesions as it is a sign of a fungal infection. The FMS is appropriate, but an external fecal pouch would have been another appropriate alternative.</p>
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Reviewed by: _____ Date: _____

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