



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

Daily Journal Entry with Plan of Care & Chart Note

Student Name: _____ Tatiane Abud Pimentel _____ Day/Date: 01/16/2024

Number of Clinical Hours Today: 11 Care Setting: Hospital Ambulatory Care Home Care Other:

Number of patients seen today: 5 Preceptor: Candace Beeghly

Journal Focus: Wound Ostomy Continence Combination Specify: _____

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, select one patient each clinical day. Provide assessment information and write a chart note. Using this information, develop a plan of care (POC) which directs care.

This 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. Provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor. Submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day. See samples in course to assist you with this assignment.

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Today's WOC specific assessment

Assessment includes a chart review. Identify PMH, HPI, labs, etc. Be sure to include data that supports the reason for the WOC nurse consult.

Patient with a history of Colon polyps, who is brought in by a concerned neighbor after being found sitting in his own feces. Patient stated that he had incontinence of stool earlier and noted that it happens off and on, but decided not to clean up. He added that sometimes he is able to tell when he goes and when it is happening, but sometimes he cannot stop it from happening before he makes it to the bathroom. The patient denied chills, fever, hematochezia, melena, and vomiting. During the MD assessment, a bloody wound was noted in the buttocks, and a consult was placed with the WOC nurse for further evaluation and treatment.

According to medical records, patient was recently discharged three days ago. Prior to admission, he had the same chief complaint: a neighbor found him sitting in his own feces. The screening test and colonoscopy from prior admission have shown colon polyps (4mm in diameter and smaller). A biopsy was done, and according to the pathologist's findings, the patient is at relatively low risk for malignancy. Patient was discharged to follow up with an out-patient colorectal clinic.

PMH: non-insulin-dependent type 2 diabetes mellitus, hypertension, anxiety, depression, and colon polyps. Surgical history of hand surgery and colonoscopy (January 12, 2024).

Family history of colon cancer in his mother's brother and colon polyps in his brother.

He reports that he quit smoking about 25 years ago. His smoking use included cigarettes and marijuana. He has a 10.00 pack-year smoking history. He has never used smokeless tobacco. He reports that he does not currently use alcohol after a past usage of about 30 standard drinks of alcohol per week.

Current medications: Motoprolol Succinate 50ml, Metformin, and Simvastatin. Patient stated that he has not taken any medications just because he decided to.

Chart Note: Write a chart note for the medical record for this patient encounter. Be sure to include any physical assessment, interactions, and specific products that were used/recommended for use.

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The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for..., follow-up visit for..., evaluation and management of..., etc Then, describe the visit. Write in a manner others will be able to understand and be able to interpret your plan of care.

Patient resting in bed, alert and oriented to place, person, somewhat confused by time. During my assessment, noted that patient was having a new bowel movement in the bed. WMST assessed if patient could tell if he was having a bowel movement, patient stated that he was aware it was happening, just decided not to call the nurse, and could not hold it in. WMST assessed social and environmental factors that led the patient to lie on his feces for the entire night. The patient stated that he lives by himself and there is no reason to rush to clean himself, and during the night he cannot tell if he goes or not because he is sleeping. WMST assessed if patient was taking any medication or herbal medications. The patient stated that he decided not to take any type of medication. When questioned if patient has any leakage of feces and if so, how often, the patient stated that it happens on and off for a couple years. He also stated that he had seen a colorectal years ago for this issue but never followed up. He stated that he did not have time for that. Patient denies any pain, bleeding, or incomplete sensation. WMST cleaned patient, and upon assessment, it was noted that the buttocks area has Moisture-Associated Skin Damage (MASD) due to repeated exposure to sources of body secretions, urine, and feces. The area has denuded skin mixed with gray-white and wrinkled skin; asymmetrical, ragged, and uneven in shape; maceration of the first layer of the skin; and pinpoint satellite lesions with the appearance of a fungal rash.

Management: Cleansed area with protective barrier wipes and applied moisture barrier anti-fungal cream to provide a moisture barrier against urine and feces at the same time to treat and inhibit fungal growth. PIPP was initiated, and the LAL mattress was ordered to prevent heat and moisture trapping underneath the patient. WMST discussed with RN and attending that patient would benefit from a psychiatrist consultation. WMST referred patient to outpatient Colorectal Clinic.

Recommendations:

Cleanse the wound and peri-wound area only with protective barrier wipes.

Apply moisture barrier anti fungal cream

Protect sacrum area with Mepilex Border dressing

Avoid sliding the patient up or down to prevent further shear injuries.

Implement pressure-reducing surfaces, turning scheduling, bed linens and clothing monitoring to keep patient clean and dry

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Provide position changes up in the chair and lying on the bed.

Begin scheduled toileting and encouragement of bowel at the same time daily.

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><i>1. Altered skin integrity related to skin breakdown</i></p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <p>Assess skin periodically and properly document skin assessment noting any redness, skin breakdown, and wounds</p> <p>Cleanse the wound and periwound area with protective barrier wipes and apply moisture barrier anti-fungal cream.</p> <p>Protect sacrum area with Mepilex Border dressing.</p> <p>Avoid sliding the patient up or down to prevent further shear injuries.</p> <p>Implement pressure-reducing surfaces, turning scheduling, bed linens and clothing monitoring</p> <p>Provide position changes up in the chair and lying on the bed.</p> <p>Begin scheduled toileting and encouragement of bowel at the same time daily.</p> <p>Monitor and assist patient to use the bathroom</p>	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <p>Patient will experience timely healing wound without complications or further deterioration</p> <p>Patient will maintain intact skin integrity underneath bony prominences</p> <p>Patient will have proper pressure injury preventive measures</p> <p>Accurate documentation will help to monitor effectiveness of interventions as well as process of healing</p> <p>Patient will keep skin dry and clean without bodily secretions as feces, urine, and sweat</p> <p>Patients who are unable to use the bathroom or are incontinent should have frequent monitoring and schedule toileting to keep skin dry and clean</p> <p>Patient with skin at risk for breakdown should be closely monitored, at least once a shift.</p>

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<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>Anti-fungal cream should be used twice a day, nursing staff may overdose and use it as moisturizer during every incontinence care. An excessive dosage of this medication may further irritate the susceptible skin, potentially leading to a severe reaction.</p> <p>Using an alternative anti fungal product, such as spray or powder, and wait 30 minutes before applying a regular moisture barrier is one option. This eliminates the possibility of confusion and permits the nursing personnel to apply the moisture barrier cream beyond twice daily.</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.

<p>What was your goal for the day? Were you able to meet your learning goal for today? Why or why not?</p>	<p>My learning goal was learn more about fecal incontinence associated with fungal rash as secondary infection and incontinence treatment for this issue. Developing this POC helped me research these areas and increase my understanding on how to management this issue that we often see in elderly population.</p>
<p>What are your learning goals for tomorrow?</p> <p>(Share learning goal with preceptor)</p>	<p>I would like to dive a little bit more in complex wounds settings.</p>

<p>Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc</p>	<p>This case made me think about how the elderly population can be mistreated and abandoned. Also, the elderly may live with incontinence because they are afraid or embarrassed to seek help. I learned that this subject is not frequently assessed. I would have inquired more about his social life, how he took care of himself, and if he had any help even though he lived by himself.</p>
<p>Reflection: Describe other patient encounters, types of patients seen.</p>	<ol style="list-style-type: none"> 1. NPWT 2. LLE cellulitis 3. Difficult fistula pouching system 4. Ostomy pouching system 5. WOC Nurses consul meeting

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Reviewed by: _____ Date: _____

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