Cleveland Clinic

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: 01/23/2024

Number of Clinical Hours Today: __12__ Care Setting: __x_ Hospital ___ Ambulatory Care ___ Home Care ___ Other: _____

Number of patients seen today: __5___ Preceptor: ____Candace Beeghly_____

Journal Focus: ____Wound _____ Ostomy ___X___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.

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 A-Fib, end-stage renal disease (ESRD) on hemodialysis, chronic hypoxic respiratory failure on a 3L nasal cannula, non-insulin-dependent diabetes mellitus type 2 with diabetic retinopathy and neuropathy, legally blind, Peripheral Arterial Disease s/p Left trans-metatarsal amputation, HTN, and HLD who presented to ED on 12/05/23 with complaints of chest pain and concern for STEMI. Patient admitted to the ICU, where the patient was noted with a 4.2-second pause on telemetry. EP was consulted, and a headless pacer was installed the following day. On 12/11/23, the patient sustained cardiac arrest and was intubated after ROSC (return of spontaneous circulation after chest compressions). On 12/23/23, the patient started showing signs of pericardial effusion, enlargement of the vein's neck, shortness of breath, and fanting. CT surgery was consulted. Testes showed pleural effusion and pericardial effusion on imaging without tamponade physiology. The surgery team decided that no surgical intervention was indicated. On 12/31/23, the palliative team was consulted due to patient status; he declined to be in a persistent vegetative state. The family refuses hospice care. On 01/17/24, the patient remained in a persistent vegetative state, and the family signed with hospice. The same day, the patient tested positive for

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	C. diff and was treated with vancomycin. On 01/23/24, neuro tests showed mild improvement, and an MRI of the brain showed mild chronic ischemic changes with generalized atrophy. The family decided to rescind hospice and requested PEG placement. Surgery consulted. Also on 01/23/24, WMST was consulted for the placement of a fecal management system due to multiple episodes of liquid incontinence stools and unsuccessful fecal management alternatives.

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.*

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.

After confirmation of a physician order saying to insert a Flexi-Seal Fecal Management System, WMST reviewed medical records for any contra-indication that the patient could have, such as neutropenia, trombocytopenia, suspected or confirmed anal or rectal tumor, allergies or reactions to components of the kit, radiation to the area for cancer treatment, and if the patient had rectal surgery within the last year, none was noted. Upon patient assessment, WMST was able to rule out final contraindications such as suspected or confirmed rectal mucosal impairment, any rectal or anal injury, hemorrhoids, and stenosis, and confirmed that the patient met all criteria for the insertion of a fecal management system. During assessment, WMST also noted perineal skin, scrotum, and inner thigh skin denuded, most likely due to moisture-associated skin damage from stool incontinence exposure. Cleansed area and applied Calazime moisture barrier cream. Pressure injury prevention was also implemented, such as offloading boots, a special low-air-loss mattress, and Mepilex Border Foam placed on the sacrum, elbows, and heels.

Management: Explained the procedure to the patient and his family and requested privacy for the patient. Placed patient on left side with knees flexed. Separated buttocks and assessed the external area for fissures, skin tags, rectal prolapse, and hemorrhoids. Performed a digital rectal exam to check for adequate rectal sphincter tone (tone was adequate for insertion). Removed residual air from the ballon and attached a syringe filled with 45 ml to the inflation port (marked 45 ml). Placed an incontinent pad under the patient. Insert a lubricated gloved index finger into the retention ballon cuff finger pocket. I applied lubricant to the ballon end of the catheter and gently inserted the ballon end through the patient's anal sphincter until it was beyond the external orifice and well inside the rectal vault. I carefully removed the finger as the

balloon was being inflated. When I inflated the balloon with 45 ml of tap water, the indicator bulb expanded and popped up, meaning the optimal level was reached. I removed the syringe and gently pulled the cachet to check the ballon security. The black position indicator line was at the level of the patient's anus. I positioned the patient comfortably and positioned the tubing along the patient's legs in a neutral position so it could freely drain without obstruction. Dated insertion date in the tubing and hanged bag by the strap on the patient bedside, lower than the patient. Finally, educated nurses about the fecal management system and emphasized that FlexiSeal should not be used for more than 29 consecutive days.

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**

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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*** ***1. Altered skin integrity related to constant exposure to feces and body fluids.***	**Statements should be directive and holistic relating to the problem/concern.** • RNs and CNAs observe the device every 4 hours for obstructions from kinks, solid feces, and partial or external pressure. • Critical care RNs or RNs who have received education and demonstrated competency rinse the FlexiSeal tube every shift with 50 ml of fluid using the irrigation port. • RNs and CNAs change the collection bag as needed. • Bedside nurses observe proper positioning of the black indicator line at the anal sphincter every shift and in every incontinence care. • Every shift and as necessary, bedside nurses cleanse the perirectal area with soap and water, then apply a thick layer of zinc barrier cream (moisture barrier skin protectant paste) to the anus and surroundings to protect the skin from seepage and improve the healing process. • Nurses should notify the physician immediately if rectal pain, rectal bleeding, or excessive stool leakage around the device occur. •	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** Fecal management device will work properly, and patient skin will be free from feces exposure. Patient will improve skin integrity and remain free of infection. Fecal management system will help keep skin clean, dry, and free from contaminants. Fecal management system will be irrigated constantly, keeping tubes clean, free of blockage, and minimizing odor. Fecal management system will be working correctly, and patient safety will be achieved.

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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?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Calazime has zinc on it and would be beneficial for denuded skin, however for this patient with severe denuded skin, I would recommend using a hydrophilic paste that also contains zinc oxide, such as Triad from Coloplast. This paste helps to dry the affected area and also promotes gentle autolytic debridement.

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 the day? Were you able to meet your learning goal for today? Why or why not?	My learning goal was to learn more about complicated wounds, however developing this POC helped me research about fecal management system and FlexiSeal and increase my understanding of how to manage fecal incontinence. It was a such good experience that I would like to share.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	I would like to continue to learn about complex wounds settings.

Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	This case got me thinking about how many families and their suffering go unnoticed by healthcare professionals. The patient's family was in the room, displaying visible suffering, and most of the nurses were annoyed by the patient's family's simple requests. I would offer some comfort and show kindness towards their feelings.
Reflection: Describe other patient encounters, types of patients seen.	1. Ostomy teaching 2. Fistula patient 3. NPWT 4. Braden skin assessment

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Reviewed by: _____ Date: _____

References:

Hydrofera Blue. (2021). Hydrofera Blue ComfortCel® Interface Antibacterial Foam Dressing: Pull your patients into the comfort zone. Manchester, Connecticut, USA: tradmarks hydrofera blue.

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