

Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Allison Salomon_____ Journal Completion Date: ___2/22/24_____

Setting: ___ Acute Care ___ Outpatient ___ HHC ___ Other ___ Virtual_____

8 hours

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 biliruben 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

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Step Mattress, Alb 2.3, BMI 27.1 FMS has been in place for 15 days. Nurses notes indicate system 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><i>Risk of Skin breakdown due to both fecal and urinary incontinence.</i></p>	<p>Statements should be directive and holistic relating to the problem/concern.</p> <ol style="list-style-type: none"> 1. Continue with internal fecal management system while pt has liquid stools and is unaware of stooling to prevent moisture-associated skin breakdown. 2. Maximum use of FMS is 29 days. 	<p>Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.</p> <ol style="list-style-type: none"> 1. The internal fecal management system helps to contain and manage loose liquid stools, while allowing the skin to heal and to prevent skin from further IAD. 2. Product guidelines 3. If leakage around FMS,

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	<ol style="list-style-type: none"> 3. Monitor for leakage of stool surrounding FMS 4. Re-consult WOC RN for excessive leaking 1. Cleanse red areas gently with no rinse peri-cleanser after each bedpan use or incontinent episode. 2. Apply Critic Aid Clear AF skin barrier (AF-2% miconazole nitrate) to reddened areas. 3. Do not use briefs unless ambulating 4. Keep bed linens to one bed sheet, one open draw sheet and one absorbent pad under patient 5. Use mechanical lift when moving patient up in bed 6. Roll patient to place or remove bedpan 	<p>may indicate a blockage or needs to be readjusted</p> <ol style="list-style-type: none"> 1. Appropriate and regular skin care after incontinent episodes helps to maintain skin integrity and prevent from skin breakdown from stool. 2. Moisture barrier cream with Miconazole nitrate is an antifungal agent to treat the fungal rash noted by the satellite lesions present 3. Briefs contain moisture and trap moisture which may create further skin breakdown, therefore should not be utilized. 4. Limiting layers in the bed helps to prevent bulk, and friction. 5. Helps to prevent shearing damage. 6. Rolling helps to prevent friction and shearing.
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<p>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?</p>	<p>This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.</p> <ol style="list-style-type: none"> 1. Internal fecal management system This product works to help contain loose stool. One disadvantage is that it can cause anal erosion or ulcerations. Additionally, if the stool thickens, the stool may be too thick to pass through the tubing and leak around the internal balloon. An alternative product that can be utilized is an external fecal pouch, if the perianal skin is intact. 2. Critic aid AF- Although moisture barrier creams such as criticaid clear antifungal are very effective, if utilizing a protective foam dressing to protect the sacrum, it may interfere with its adherence. An alternative product may be to utilize miconazole power to treat the fungal rash and to help minimize moisture to the denuded skin.
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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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What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	
What are your learning goals for tomorrow? (Share learning goal with preceptor)	

Reflection: Identify/describe thoughts related to the mini case scenario, anything you might have done differently, etc	<p>This case study is one example of many similar patient encounters that I am consulted for in my workplace. A young patient, who presumably had no prior history of pressure injuries, now at a high risk for pressure injury development. As a WOC nurse I would implement a similar plan of care. The first issue is to address the current presentation of the skin, in this case study, a fungal rash. The second intervention is to manage the liquid stool by placing an internal fecal management system. Lastly, having a specialty mattress such as the first step, and safely turning and repositioning the patient works to prevent further skin breakdown or pressure injury development.</p>
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Reviewed by: _____ Date: _____

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