Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Amy Harlan Day/Date:_____

Setting: Hospital ☒ Ambulatory Care • Home Health Care • Other: _____

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 chart review and assessment information are provided for you. Use this information to write a chart note and to develop a plan of care.

Chart Review/History

Age/sex: 89-year-old male
PMH: afib, CAD, diabetes, and dementia. History of urinary and fecal incontinence, poor appetite requires to be fed. Non-verbal and follows commands. Non-ambulatory, transfers with standby assist.
CC: presented to emergency room via ambulance from nursing home for change in mental status.
Meds: Not available at time of chart review
Social hx: Resides in long term care, Patient is non-verbal and not oriented at baseline.

Labs: Pending

ED Braden Score:

Sensory Perception	3
Moisture	2
Activity	2
Mobility	2
Nutrition	2
Friction/Shear	3
Total	14

WOC nurse consulted by primary ED nurse due to concerns for red skin on buttocks and perineal area after arriving in urine-soaked brief.

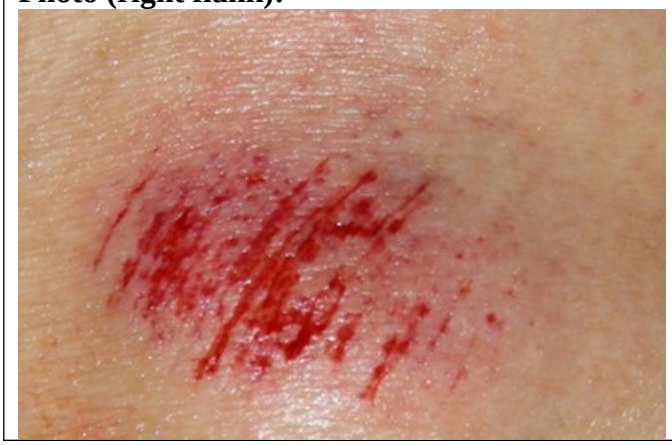
Assessment/encounter:
Prior to this visit, nursing placed external urinary catheter and connected to gravity drainage. Draining yellowed colored urine without sediment.
LOC: Non-verbal and follows commands. Pleasant, disoriented, cooperative.
VS: Temperature: 99.9F, Pulse: 102, Respirations: 26. No non-verbal signs of pain.
Initial interview: unable to obtain as patient is only oriented to self. Patient noted with unkept fingernails.

Skin assessment:
Patient turned to the left side. Brown stool noted to be oozing on assessment.
Location: Back, buttocks & inner thighs

Skin breakdown type: Mild excoriation
Extent of tissue loss: superficial, isolated to bilateral flanks.
Size & shape: <1 cm, oval
Wound bed tissue: pink
Exudate amount, odor, consistency: None
Undermining/tunneling: None
Edges: poorly defined.
Periwound skin: blanchable, general erythema
Pain: None; Patient noted to be scratching at area upon turn.
Rectal assessment: Moderate rectal tone, incontinence noted

Education: identify in note
Suggested consults: identify in note

Photo (right flank):



Using critical evaluation of the provided encounter data, identify what would you have done differently regarding assessment data collected, treatment recommendations, and education?

1. Identify what would you have done differently regarding assessment data collected, treatment recommendations, and education?

Abdominal and skin assessment, digital rectal exam- any hard/ impacted stool? UA/culture for infection, assess urine clarity, color, amount, odor. Bladder scan, labs for electrolytes, dehydration, kidney function. Stool specimen for GI PCR/ c-diff. Look over EMR for GI history, surgeries, comorbidities, urology history, prostate health. Contact nursing to obtain more health history, medications, etc. Patient inappropriate for education at this point due to confusion. Assess further into lungs to determine cause of fast RR.

Using the information from the encounter and your critical evaluation develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders. (For example: *What dressing change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

- Use male external condom catheter, change every 8 hours.
- Increase fluid/ nutritional intake – Dietitian Consult
- Treat urinary and/or stool infections with IV antibiotics- Infectious Disease Consult

- Tylenol q6H for pain and or fever above 101F, per Physician orders.
- GI/ Urology consults. Start PT/OT for bed mobility, ADLs, gait and strength training.
- Turn q2H with use of foam wedges. Use Prevalon boots.
- Apply Citric-Aid to buttocks and perineal area in a thin layer BID and PRN to protect skin.
- Use Prevalon Turn and Position system glide sheet when repositioning patient/ pulling him up in bed.
- Use ConvaTec Flexi-Seal FMS until stools start to thicken. Irrigate with NS for no flow of stool in 24 hours through blue irrigation port and slowly depress syringe.
- Check Blood Glucose ACHS and using SS Novolog insulin PRN, per Physician orders.
- CNA to feed patient all meals in a fully upright position to help increase nutritional intake.
- Use contact isolation precautions for c-diff. Wash hands with soap and water. Use bleach to clean equipment, counters, etc. All visitors to follow contact precautions.
- WOC will continue to follow. Re-consult WOC team for any urgent problems or worsening skin conditions.

Write a chart note giving careful consideration to the chart review information, how the patient was assessed, the problems, and the rationale behind the plan of care. 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. Be sure to include any physical assessment, interactions, and specific products used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

3. Chart note:

This is an initial visit for a 89-year-old male consulted due to concerns for red skin on buttocks and perineal area after arriving to ER in urine-soaked brief. Patient has a medical history of a-fib, CAD, DM, and dementia. History consists of urinary and fecal incontinence, poor appetite requires to be fed, non-verbal but follows verbal commands, non-ambulatory but transfers with SBA. Patient presented to ER via ambulance from nursing home for AMS. Patient scored 14 on the Braden Scale. Patient was using external urinary catheter connected to gravity drainage at the facility that contained yellow urine. Patient is pleasant and cooperative but disoriented. Patients' vital signs are slightly elevated with a temp of 99.9F, pulse of 102, and RR of 26. Patient not showing any non-verbal cues of pain. Patient has mild excoriation to bilateral flanks that is superficial, poorly defined edges, less than 1cm, oval shaped, and peri-wound skin erythema that is blanchable. Patient has been scratching flank areas; moderate rectal tone with stool incontinence. Patient had stool oozing onto back, buttocks, and inner thighs. Patient cleaned thoroughly with bathing wipes and gently dried. Applied thin layer of Citric-Aid to buttocks, perineal area and lower back. Patient positioned onto right side with use of guide sheet and foam wedges. Reports given to bedside nurse and instructed on using male external condom catheter, FMS and Prevalon boots.

You should have a learning goal for each clinical day. What was your goal or reason for choosing this particular mini case study? Were you able to meet this goal? Why or why not?

4. What was your goal for choosing this case?

My goal for choosing this case was to learn on how to better manage patients with both urinary and fecal incontinence. I have not had a patient with both and to learn options for skin health.

Reviewed by: _____ Date: _____

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CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen		
• Describes the encounter including assessment, interactions, any actions, education provided and responses		
• Includes pertinent PMH, HPI, current medications and labs		
• Identifies specific products utilized/recommended for use		
• Identifies overall recommendations/plan		
Plan of Care Development:		
• POC is focused and holistic		
• WOC nursing concerns and medical conditions, co-morbidities are incorporated		
• Statements direct care of the patient in the absence of the WOC nurse		
• Directives are written as nursing orders		
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter		
• Identifies alternatives/what would have done differently		
Learning goal identified		