Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Janella Bryant 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.

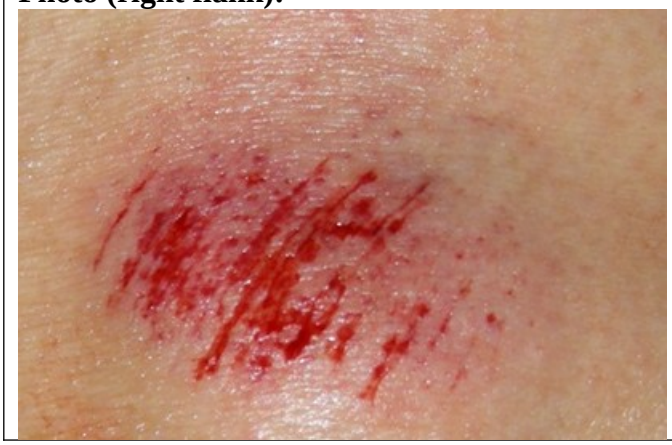
Assessment/encounter:
Prior to this visit, nursing placed external urinary catheter and connected to gravity drainage. Draining yellowed colored urine without sediment.
LOC: Non-verbal and follows commands. Pleasant, disoriented, cooperative.
VS: Temperature: 99.9F, Pulse: 102, Respirations: 26. No non-verbal 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?

This pt appears to be suffering from IAD r/t exposure to urine and feces. It's unsure how bad the fecal incontinence is due to limited assessment details. Treatment will involve controlling the source of moisture by limiting exposure and protecting the exposed skin. The use of urinary diversion devices like condom caths or external urinary devices can assist with that. Fecal diversion devices can be beneficial if the patient is having large amounts of liquid stool. While the pt is hospitalized I would recommend that the external urinary device remain in use. For fecal incontinence I would suggest to use of a skin protectant along with a brief and frequent bed checks until the extent of the fecal incontinence can be further assessed. If the pt is noted to have large amounts of liquid stool, then a internal fecal device can be place. Pt education is limited r/t the pt orientation, so education will be deferred until discharge and given in writing along with discharge instructions to the facility. The wound located to the right flank is likely caused by candidiasis r/t the presentation.

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)

- Clean skin with PH balanced cleaner.
- Dry and apply Medline Remedy clinical zinc oxide paste skin protectant to the areas of the skin that will be in contact with moisture. With every change
- For the wound located to the right flank from scratching- apply nystatin ointment and cover with a small Meplex for protection. Change PRN or when soiled
- Place the PrimoFit external catheter to urine incontinence. Assess and change the device TID or when soiled.
- For fecal incontinence, apply Medline Remedy Clinical zinc oxide paste skin protectant around the anus, buttocks, and inner thighs to create a bar to protect skin for episode of incontinence and a place brief.
- If stool becomes fully liquid with frequent episodes, place ConvaTec Flexi Seal fecal management device following manufacture instructions.

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:

89 yr old man with a h/x of afib, CAD, diabetes, and dementia, who is nonverbal, non-ambulatory and not orientated at baseline was brought to the ED for change in mental status. Vitals show mild temperature and elevated HR. Pt is incontinent of bladder and bowel at baseline and has a Braden score of 14. On assessment, the pt was observed wearing a urine soiled brief, his buttocks and peri area skin was redden and liquid stool was noted oozing from the rectum. Pt was also seen scratching his right flank where a redden rash was observed. Taking in consideration the orientation of the pt, a treatment plan was implicated involving the management of IAD and the candidiasis rash to the right flank. Education given to staff on following the facility interventions for patients with low Braden scores and skin care instructions. Detail instructions on peri care and wound care will be provided to the facility on discharge for continuous care.

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?

I chose this because IAD is a common issue seen in the clinical setting and understanding how to treat it is important.

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Reviewed by: _____ Date: _____

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		