Cleveland Clinic

R. B. Turnbull Jr. MD WOC Nursing Education Program

**Virtual Journal Entry with Plan of Care & Chart Note**

Student Name: Brendan Agatisa-Boyle Day/Date: 7/29/25

Setting: Hospital X 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*:32-year-old female
*PMH*: unknown
*CC*: Presented to ED after being revived in the field by paramedics. Patient was found by roommate lying on couch and unresponsive. Responsive and confused in the ambulance. Unable to obtain information related to altered mental status likely due to hepatic encephalopathy.
*Meds*: Unknown
*Social hx*: Roommate reported frequent drug use with recent known use of meth

Labs: K 2.4, bicarb 19, lactate 2.9, myoglobin 113, UDS opiates positive ammonia 226, and bilirubin 2.9.
CT and MRI head negative for stroke.

*ED Braden Score*:

| | |
|---|---|
| Sensory Perception | 1 |
| Moisture | 3 |
| Activity | 1 |
| Mobility | 1 |
| Nutrition | 1 |
| Friction/Shear | 1 |
| Total | 8 |

Transferred to ICU, intubated for impending airway compromise.
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

**Assessment/encounter:**
WOC nurse referral 15 days post admission to hospital for reinsertion of FMS & patient buttocks/thighs skin breakdown.
Transferred to medical unit from ICU 2 days prior.
Internal fecal management system in use for past 15 days, but has fallen out.
*LOC*: awake, alert, oriented to name but groggy; follows commands

*VS*: Temperature: 99, Pulse: 92, Respirations: 26
*Initial interview:* unable to obtain as patient is groggy

*Braden Score*: from AM by nursing staff

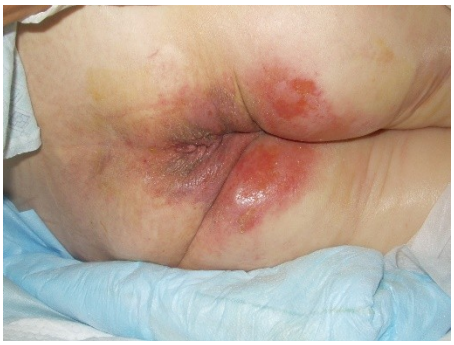
| | |
|---|---|
| Sensory Perception | 4 |
| Moisture | 3 |
| Activity | 1 |
| Mobility | 3 |
| Nutrition | 2 |
| Friction/Shear | 2 |
| Total | 15 |

**Skin breakdown assessment**:
*Location:* buttocks & inner thighs. Buttocks and pads soiled with liquid stool brown/yellow, reported to be constantly oozing stool
*Skin breakdown type:* MASD
*Extent of tissue loss:* superficial
*Size & shape:* Scattered raised papules on perianal area, with satellite lesions.
*Wound bed tissue:* pink
*Exudate amount, odor, consistency:* None
*Undermining/tunneling:* None
*Edges:* Attached
*Periwound skin:* non-blanchable erythema to buttocks & thighs
*Pain:* Not able to rate but grimaced on cleansing and pain apparent by patient comments
*Rectal vault assessment:* Moderate rectal tone noted and no stool obstruction.
Occasional urinary incontinence

*Education*: Collaborate with physician regarding drug use, liver involvement, life style

*Suggested consults*: identify in note

**Photo:**



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**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?**

The assessment provided comes 15 days post admission and should have been done much sooner. ***Based upon data, the WOC nurse was consulted related to FMS. Many ICU nurses can insert an FMS, whereas, other units do not permit such. In this case then, the 15 days is appropriate.*** The patient should have had a skin assessment done upon arrival to the ED, especially because the patient was found unresponsive, again when she was transferred to the ICU and again when transferred to the medical unit two days ago. ***Good. We do not know if this was done as the information does not indicate.*** It would have potentially been advisable to have consulted WOC earlier as well. If the earlier skin checks had been performed the skin break down around the FMS may have been noted and the WOC consult could have been placed earlier. A FMS should only be left in place for 29 days, however the perianal area should still be cleansed regularly and a barrier cream utilized to prevent skin breakdown in the case of any leaks or the system falling out.

**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)**

-Prior to placing a FMS it is important to identify if it is appropriate for the patient
  -If the patient is immobilized or critically ill
  -Frequent liquid stools
  -Risk of perennial skin breakdown
  -Absence of severe hemorrhoids or rectal/anal bleeding
  -Patient is not allergic to any materials in the device
-Once the patient is deemed appropriate gather supplies
  -The FMS kit
  -Water soluble lubricant
  -Gloves
  -Syringe for balloon inflation
  -Skin barrier product

***Check balloon patency?***

-Explain the procedure and the rational to the patient
-Lay the patient down
-Place them on their left side
-Clean the perineal area with gentle soap and warm water
-Lubricate catheter tip generously
-Connect syringe to balloon inflation port and remove any air in balloon
-Place index finger into pocket on balloon
-Gently insert into the rectum until you reach the marking line or resistance
-Inflate the balloon with water (not air) until the green marker on the inflation port inflates (usually around 45 mL). Do not inflate to the point of the red marker inflating. If the red marker is inflated pull back until both markers deflate and slowly instill water until the green marker is inflated.

-Gently pull back on FMS to seat the balloon against the rectal wall
-Hang collection bag on designated hooks on side of bed
-Write date of insertion on side of tubing
***The WOC nurse was consulted for insertion, therefore, staff would not be doing so and this information would not be part of the POC>.***
-Managing a patient with a FMS:
-Monitor output, output should be liquid and flow easily into collection bag
-Empty collection bag regularly to prevent output backing up into tube ***Be specific, quantify. Empty collection bag when half full***
-Flush the FMS with 50 mL of potable water once a shift and PRN, using the flushing port (Not the inflation port). When flushing patient should be in left lying side position
-Assess perianal skin for breakdown every shift ***Then what? What should be done with the information?***
-Watch for signs of rectal bleeding, FMS leakage, pressure injury, or discomfort ***Then what?***
-Cleanse perianal skin once a day and PRN ***With anything in particular?***
-Make sure tubing is not kinked or under tension
-Utilize turn and wedge system turning patient every two hours
-Check tubing is not trapped under patient's legs or causing pressure on their skin
-Assess that green marker on inflation port is inflated but not the red marker ***Then what?***
-Note on tubing the date of insertion. FMS should not be in place for over 29 days ***Then what? Remove? Place a new system?***
-Assess daily for continued need / appropriateness of system ***Then what?***
-Remove when stool starts to become formed or when device is no longer indicated ***How would one note the FMS is not longer indicated? You mention formed stools.***

-Per shift documentation should include:
-Date of insertion
-Balloon inflation volume
-Stool output (volume, consistency and color)
-Skin assessment
***While this is true, the information is not directive. Would date of insertion be documented every shift?***
-If skin breakdown is noted during assessment consult with WOC nurse for further management ***WOC nurse has been consulted and skin breakdown is present***
-Consult with infectious disease team to monitor patient ***What data indicates this is necessary?***
-Monitor the patient for signs of infection (increase WBC count, fever, redness or swelling around the perineum). If any of these signs are noted notify the provider immediately and remove FMS if indicated.
-Consult with nutrition team to promote a diet (or if needed tube feeding) that will maintain patient nutritional needs while keeping stool consistency appropriate for the FMS while it is needed
-Requiring a FMS can be difficult for patients to manage, consult with Psychiatry to help with patient anxiety or depression ***What data indicates this is necessary?***

***This POC is very generic and reads as if the content was "borrowed" from a source. It lacks inclusion of data provided and does not support the transition from bedside to that of specialist.***

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**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 32-year-old female was seen due to needing reinsertion of FMS and assessment of buttocks/thighs skin breakdown. This patient came into hospital after being found unresponsive. She initially had a FMS placed in the ICU due to the patient needing intubation and having frequent liquid stools. She presents in the medical unit 2 days post leaving the ICU. Patient is alert and oriented though is very groggy at this time. The bedside nurses note that during their assessments the patient is constantly oozing stool and is saturating her bed pads. She has evident MASD along the inside of her thighs and buttocks (see attached picture) with superficial skin loss. There are scattered raised papules on the perianal area, with satellite lesions. There is no sign of exudate or foul odor coming from the wound. Wound edges are attached and the periwound skin is non-blanchable erythema. Patient was unable to describe pain due to grogginess however grimaced during cleansing indicating an 8/10 on the FACES pain scale. After cleansing a new FMS system was inserted utilizing a generous amount of surgical lubricant. During insertion moderate rectal tone was noted with no stool obstruction. Desitin was then applied to the perianal area, buttocks and thighs in a thin layer and her pad changed out for a new clean and dry one.

WOC nursing will continue to follow this patient and will have a follow up visit with the patient to re-assess her skin and the FMS system a week from today.

***Information from your note should be in your POC. What about attention to the satellite lesions?***

**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?**

Getting experience with Continence during the clinical period was difficult and I did not get any patients with a FMS. I wanted to get some more experience with FMS as it is something that as a continence specialist I will certainly need to know about in detail. I think that I learned a lot about FMS management throughout the process of doing research for this case study, and feel more confident in my ability to manage or advise bedside nursing on the management of FMSs.

Reviewed by: Kelly Jaszarowski Date: 7/30/2025

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