Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Regina Averyanova Day/Date: 07/27/2025 **Received 7/30/2025**
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: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

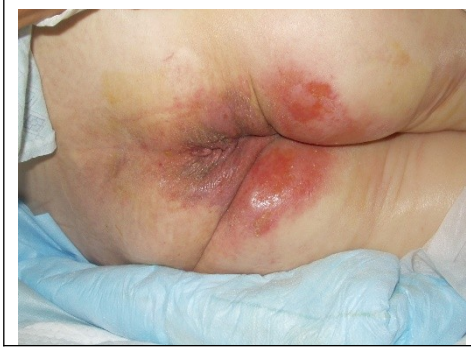
Sensory Perception	4
Moisture	3
Activity	1
Mobility	3
Nutrition	2
Friction/Shear	2
Total	15

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:



Cleveland Clinic

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

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?

There are additional things that I would like to gather on this patient. According to Braden scale, patient's mobility is 1, which indicates the patient is bedbound. Is this patient on any anticoagulants? Does she have any clotting disorders? Patient's bilirubin was elevated 2 weeks ago, and this might indicate liver damage. I would like to see more recent lab results for this patient, as well as any diagnostic tests that were done (CT scans, x-rays). Does this patient have any allergies? These are important factors to consider prior to using FMS, because there are contraindications of using FMS, such as clotting disorders, allergies to the product, rectal/anal injury, etc. (Callan & Francis, 2022, p. 500). ***Good!***

The stool should not be constantly oozing from the FMS. It is important to check whether the ballon is inflated with the appropriate volume of fluid. The device should not be used for more than 29 days, and it is important to monitor the length the device has been inserted (Callan & Francis, 2022, p. 501). Additionally, can the patient try stool bulking agents? Since patient's sensory perception is intact, will she be able to notify the provider when she needs to defecate. It is important to consider patient's ability to defecate and to promote movement and overall functional status whenever possible. Also, patient is occasionally incontinent of bladder. How is this being managed? Can the patient call the nurse when she has to void? Additionally, I would like to know how this patient is meeting her nutritional needs. Is she on parenteral or enteral nutrition? In summary, I would want to know more about patient's mental status, whether it fluctuates throughout the day, where patient is more alert later in the day. How does the patient verbalize her needs? Additionally, I would want to know about her nutrition, mobility, and continence status, as well as recent lab results, medications, and FMS function.

From the skin assessment, it looks that patient has developed incontinence associated dermatitis (IAD) with a secondary fungal infection – candidiasis. The most important goal in healing IAD is to manage the incontinence and to promote continence (Thayer & Nix, 2022, p. 368). To do this, patient would benefit from toileting programs and bowel/bladder training programs. Patient would greatly benefit from physical therapy for overall mobility improvement and pelvic floor strength.

I would educate nurses on the importance of repositioning the patient every two hours and to provide regular incontinence care, which includes using no rinse liquid cleanser or water. Nurses would need to be educated on how to insert FMS and how to inflate the ballon with the appropriate volume for each patient not exceeding 45 ml. Also, nurses must be educated on how to apply the barrier cream and antifungal product. Moreover, I would teach nurses to avoid rubbing the skin and to avoid friction when repositioning the patient. ***Good! Overall, well done.***

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)

- Provide pain management as ordered
- Implement toileting schedule q 2hours
- Use no rinse liquid cleanser when providing incontinent care. ***How often should care be provided?***
- Gently wipe the skin, avoid rubbing.
- Apply antifungal powder to the affected area thinly and dust off excess

- Cover the affected area with the zinc containing barrier cream after antifungal power application. ***Is there a commercial product that is zinc based with an antifungal incorporated?***
- Assess perineal, gluteal, groin, and inner thigh area every shift and with every incontinence care ***Then what?***
- Check FMS and address any leakage of stool ***How? What should be done?***
- Check the FMS ballon placement and that appropriate amount of fluid is filled (no more than 45 ml or when indicator is fully expanded) ***How often? Then what?***

- check that the FMS tube is not kinked every two hours. ***Then what?***
- Consider irrigation if stool is not draining or leakage persists. ***Then what? Be directive***

- Reassess stool texture every shift and PRN and if solid stool is present, discontinue FMS, notify LIP
- Follow up with the physical therapy for pelvic floor exercises.

Information is general and tends to lack direction. Note my comments

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:

WOC nurse was consulted for initial visit for reinsertion of FMS and patient buttocks/thighs skin breakdown. This is the fifteenth day of post admission. Patient has developed non-blanchable erythema to b/l buttocks and thighs that has scattered red papules with satellite lesion. Tissue loss is superficial. The area is painful to touch. Based on this assessment, patient has incontinence associated dermatitis (IAD) with secondary fungal infection candidiasis.

Since this patient is experiencing pain, it is important to provide pain management control prior to incontinence care as ordered, ***This is a rationale type statement. Would you write such in your medical record note?*** and pain management was provided at today's WOC nurse visit. ***Identify specifically how the pain was managed; medication, distraction, deep breathing, etc***

Patient has occasional urinary incontinence and it is important to initiate the toileting schedule every two hours and PRN. ***This is a rationale type statement. Would you write such in your medical record note?***

Every time toileting is offered, it is important to check FMS and to address any leakage of stool. ***This is a rationale type statement. Would you write such in your medical record note?*** If leakage is observed check the ballon placement and that appropriate amount of fluid is filled (no more than 45 ml or when indicator is fully expanded). Also, check that the FMS tube is not kinked. If stool is not draining or leakage persists, consider irrigation. It is important to reassess stool texture and if solid stool is present, discontinue FMS and notify LIP.

No rinse, pH balanced cleanser with surfactant would help minimize surface tension. Additional gentle wiping will help minimize the friction and will help minimize further skin damage (Thayer & Nix, 2022, p. 370). Since patient has secondary fungal infection it is important to use antifungal product to stop the infection, and it is important to use moisture barrier cream to promote the healing and alleviate the

discomfort. ***Reads as a POC, rationale***
Pharmacy consult was placed to evaluate the medications that might contribute to the incontinence (only if lactulose was stopped, it is unclear from the scenario). Nutritionist consult was also placed to help improve the oral food intake. Referral to PT was placed for pelvic floor PT to improve overall mobility and help strengthen the pelvic floor. ***Ok***

Keep in mind, the chart note should mimic what you would document in the medical record reflective of the patient encounter

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 work with patients who experience bowel and bladder incontinence, and unfortunately IAD is a common problem in the acute and long-term setting. My goal was to learn how to address this issue and how to provide a potential solution to this problem and prevent further complications. I think my goal was met because I was able to study this topic more in depth, and to see the multifactorial aspect of treating this issue with the goal of continence promotion and minimizing complications. ***Good!***

References

Callan, L. L., & Francis, K. (2022). Fecal incontinence: Pathology, assessment, and management. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 484-519). Wolters Kluwer.

Thayer, D., & Nix, D. (2022). Incontinence associated dermatitis. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 355-372). Wolters Kluwer.

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

Keep in mind, these virtual journals should provide you with the information to write a chart note which mimics an actual patient encounter. Note should tell the story of the visit; why consulted, assessment, treatment, teaching, etc. From this information, the POC should direct how the patient should be cared for in your absence. Note my comments throughout.

Cleveland Clinic

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

For instructor use only. Do not remove or edit

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	✓	
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	