Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Theresa Farley Day/Date: Virtual Journal 1 (Continence)

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.

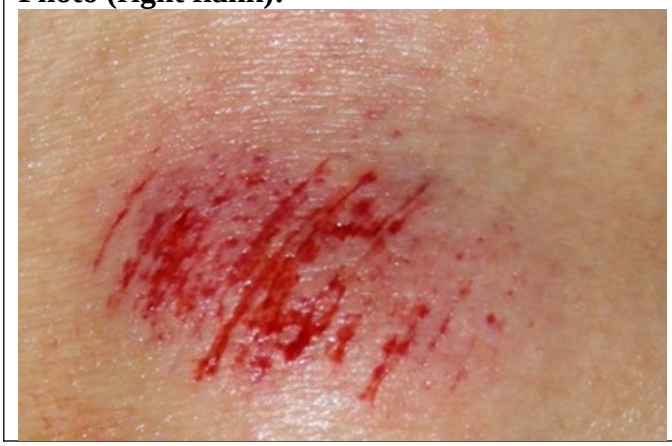
Assessment/encounter:
Prior to this visit, nursing placed external urinary catheter and connected to gravity drainage. Draining yellowed colored urine without sediment.
LOC: Non-verbal and follows commands. Pleasant, disoriented, cooperative.
VS: Temperature: 99.9F, Pulse: 102, Respirations: 26. No non-verbal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

Assessment

- Due to the multiple risk factors, a full skin assessment and interventions to reduce pressure injury should be implemented.
- Prior to placement of the catheter, it would have been helpful to assess if patient was able to toilet with urinal or bedpan since he is noted to follow commands. A bladder scan would have also been helpful to identify if there is any retention.
- Physical assessment should include PAIN-AD scale, full skin assessment, and assessment for dehydration. Full labs (renal function, CBC, CMP, etc.) are also needed to get a clearer picture of this patient's condition.
- Thorough review of the nursing home records would also be helpful, including medication list (is he taking something to address incontinence or something that may impact incontinence) and prior history, especially ADL performance (even being oriented x1 does not indicate that the patient is unable to void, he may do so at the LTC facility).

Treatment

- Interventions should be placed to prevent skin breakdown related to pressure, such as elevating heels, LAL mattress if inpatient, frequent skin assessments, use of barrier cream, and correctly fitting brief.
- While in this case, a catheter was placed to manage urinary incontinence, there is no mention of how the fecal incontinence is being managed (frequent changes, brief, etc.).

Recommendations

- A urine culture and CBC is needed. Patient does have a temp of 99.9 and a pulse of 102, which may indicate movement toward sepsis. This could indicate UTI, and it should be ruled out. He also has increased respirations, so ideally, a full work-up would be completed to rule out respiratory infection, as well.

Education

- It would be helpful if there was a standard protocol for urinary and fecal incontinence that the ED nurse could have followed when the patient came in.

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)

- Cleanse perineal area with a pH balanced foam cleanser after every incontinent episode. Apply Medline Remedy zinc oxide paste skin protectant in a thin layer. Do not attempt to remove all the product or to cleanse to bare skin. Product may be reapplied in thin layers as needed.
- Complete skin assessment and Braden every shift to quickly identify any changes in skin condition.
- Trim and clean fingernails to prevent additional trauma/scratching.
- Maintain external catheter until condition is stabilized. Once stable, patient will need to be transitioned to a toileting program, with assistance provided to toilet every 2-3 hours.
- Reposition patient in bed and assist to bed pan for bowel movement every 2 hours. Use low-friction repositioning sheet, Maxi Slides, to prevent friction/shear injury.
- Monitor for itching and scratching. Notify WOC and provider if this continues.
- Use Theraworx wipes to provide perineal care every shift for infection prevention (use while catheter is in place).
- Monitor catheter output every 4 hours and document in the EMR.
- Follow up with hospitalist for management of acute and chronic conditions.
- Consult with dietician to optimize nutritional status and PT/OT to determine ability to transfer and options for safe toileting.

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-year-old male is seen in ED for evaluation of red skin to buttocks and perineal area with incontinence. Patient has past medical history A-Fib, CAD, diabetes, dementia, and urinary and fecal incontinence. History of present illness began when resident was transferred from his long-term care facility to the ED for altered mental status. Chart review indicates poor appetite, requiring full assistance with meals. Patient is non-ambulatory and transfers with standby assist.

Patient is seen lying in bed in ED with urinary catheter in place, draining yellow colored urine without sediment. Patient is non-verbal at present. Unable to interview. Patient does follow commands and is cooperative with physical assessment. Patient has increased temperature and pulse and labs are currently pending. No signs of pain are observed, though patient is seen scratching back, buttocks, and inner thighs. Bilateral buttocks, inner thighs, and back notes with blanchable erythema, no exudate, no odor. Superficial tissue loss and excoriation is noted to bilateral flanks. Patient is noted with unkempt fingernails and presented to ED with soiled brief, which may contribute to scratching. Catheter in place at present, draining without difficulty, but noted stool oozing from rectal area during assessment. Moderate rectal tone noted. Patient is unable to communicate needs regarding toileting due to non-verbal status and cognitive impairment (oriented only to self). Patients does not appear in distress during episodes of incontinence, aside from scratching flank area, indicating possible discomfort/pruritis to area.

Plan of care updated to include measurement for appropriately sized briefs, use of zinc barrier cream, and foam-based cleanser with every incontinent episode. Will increase frequency of Braden and skin assessments due to risk of breakdown and implement a turning and positioning program, with attempts to toilet using bedpan every 2 hours until patient is cleared by therapy for transfers to toilet. Labs are currently pending for acute condition, but the catheter may be removed and a toileting program implemented once provider gives medical clearance. Ongoing follow up with WOC will be needed to gauge urinary and fecal incontinence and additional options for diagnostics and management.

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?

In my own practice, I often see patients that have dual incontinence and skin breakdown, so this allowed me to closely examine a case that mimics what I often see in practice. The fact that this patient is from an LTC facility, is advanced age, has some cognitive impairment, limited mobility, and functional incontinence also made this case particularly interesting to me. It is a great opportunity to really study and think about how to manage all these factors.

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	✓	
• 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	✓	