Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Alice Pownall-Gray Day/Date: 10/15/2025

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

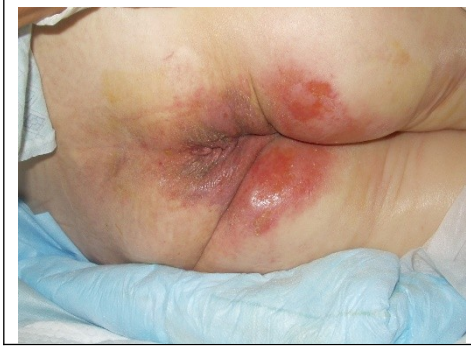
Sensory Perception	4
Moisture	3
Activity	1
Mobility	3
Nutrition	2
Friction/Shear	2
Total	15

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:



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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?

Do you believe the Braden scoring is accurate? I would have wanted to see more labs. **Such as?** I also would like to know if the patient was tested for C-diff, however I suspect the diarrhea is from the lactulose. It does not say if the patient has a catheter, but I would probably think it would be a good idea since she is showing signs of sepsis and having a catheter would be helpful to monitor her I &O plus keep her peri area drier. Or someone w potential sepsis then another indwelling tube may not be best. **What else could you do instead of a Foley?**

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)

1. Fecal Management system inserted and to be removed day 29, with prn flushes 50 ml water BID if needed for clogged tubing. **Based on the photo, what else could you do to contain stool?**
2. Daily assessment of pt tolerance of fecal management tube and assessment of stool consistency.
3. Antifungal skin barrier ointment 2-3 times daily with peri care to all areas buttocks and groin with MASD with redness and satellite lesions.
4 Assess urinary catheter function. You have to insert first

You did not address some of the scores on the Braden in your plan

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:

Initial visit:
Pt seen today for consult due to MASD and Fecal tube management system
Due to the severity and pain the patient is experiencing, the high risk of sepsis, and the raw area of excoriation and satellite lesions suggesting a possible yeast infection I would agree with use of a fecal management system. I would not recommend and oral antifungal medication (due to liver status) but rather a barrier antifungal ointment. I would use this as she is also incontinent of urine at times, and this will help to protect her from the urine.

Specific plan:
1. Fecal Management system inserted and to be removed day 29,
with prn flushes 50 ml water BID if needed for clogged tubing.
2. Daily assessment of pt tolerance of fecal management tube and assessment of stool consistency.
3. Antifungal skin barrier ointment 2-3 times daily with peri care to all area's buttocks and groin with MASD

with redness and satellite lesions.

4. Assess urinary catheter function.
5. C-diff labs pending.

Follow Up visit:
1.Re-assess effectiveness and need for fecal management system, dc when appropriate
2.Assess buttocks and peri area to see if MASD has improved and fungal rash has resolved.
3. Assess if foley catheter is patient and intact.
4 Continue to collaborate with staff RN's with management of the system and troubleshooting ie: flushing FMS if needed, pressure reduction use of antifungal ointments, alert WOC when system is no longer appropriate.
5. Educate patient related to continence care when appropriate

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 case study to meet my goal of having continence experience and being able to WOC plan and chart appropriately.

Reviewed by: Patricia A. Slachta Date: 10/29/25

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CRITICAL ELEMENTS	Completed	Missing
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter		✓
• Identifies alternatives/what would have done differently	✓	
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	✓	
• Braden subscales addressed (if pertinent)		✓
• Statements direct care of the patient in the absence of the WOC nurse		✓

• Directives are written as nursing orders	✓	
Learning goal identified	✓	