Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Jonathan Rybka Day/Date: November 6, 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

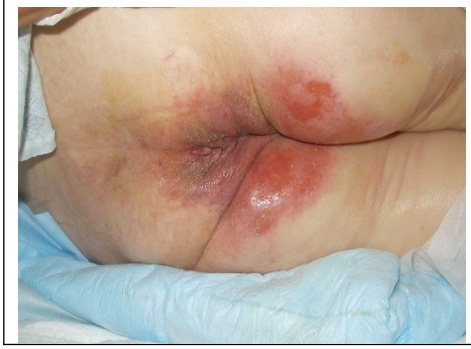
Sensory Perception	4
Moisture	3
Activity	1
Mobility	3
Nutrition	2
Friction/Shear	2
Total	15

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?

While the patient is unable to provide her own medical history, the patient's roommate may be able to provide some details or at the very least contact information for the patient's family (assuming at least a somewhat intact relationship where the patient is willing for family members to receive medical information). No information on nutrition was presented; for the sake of this journal I will assume the patient is on NG tube feedings, though if this is the case it will be obvious during patient assessment. Education during this time is not appropriate as the patient is only oriented to self and therefore can not be expected to retain any education. Current expectations for discharge planning would be helpful (LTACH vs SNF vs acute rehab, etc.) and if probable caregivers are visiting education should be done while they are present, more for the purpose of educating them rather than the patient. Based on presented information, I would also recalculate the patient's Braden score. Moisture should be a 1 if the patient is "constantly oozing stool" that leaks onto the pad and skin. Based on the patient's drowsy behavior and stage 2 PI, I would also decrease the friction/shear score to a 1 and the mobility score to at least a 2. Even if the patient is capable of a 3 mobility score that does not seem to reflect the actual situation (what the patient is capable of doing vs what the patient actually does). This would be something to discuss with nursing staff and review charting to see if Braden scores are simply copied from one shift to the next, especially since it lead to an avoidable HAPI. Lastly, there should be some initiation on discontinuation of the FMS as the patient is over halfway through the acceptable time period for a patient to have an FMS. This should be discontinued as the patient's mentation improves and it should be determined how long the patient will need to continue taking lactulose as this is the primary contributor to rationale for a FMS.

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)

- Turn patient every 2 hours using positioning wedges. Assess patient for cleanliness during turns and change absorbent pad underneath patient if stool or urine is noted on pad.
- Apply miconazole powder to inner thighs BID. Reapply prn after cleansing/bathing patient.
- Apply Coloplast Triad cream to buttocks daily.
- Use pH balanced wipes when cleansing patient.
- Apply Bard Purewick external female urinary catheter. Change daily or prn if soiled by stool. Clean perineal area during catheter changes.
- Review Braden scoring from previous shifts and discuss appropriate sub-scores with nursing staff.
- Assess FMS each shift to ensure it is properly inflated and positioned (no kinks, no more than 45 mls in balloon, green indicator is "popped" out). The FMS should not be used for more than 29 consecutive days (14 days remain as of writing this care plan). Discuss plan for discontinuation of FMS with nursing staff and primary physician.
- Discuss anticipated discharge planning with care management/social work. If family members or friends are expected to be caregivers for the patient after discharge, coordinate to plan an education session while they are present.
- Follow up weekly while the patient remains in the hospital.

- Order for a constant low-pressure mattress with low air loss (Stryker IsoFlex LAL) placed. Exchange patient bed when available.

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 patient is a 32-year-old female seen for management of a failed FMS. The patient originally presented after being found unconscious by her roommate with a suspected OD. The patient was originally admitted to the ICU for intubation and has been on a regular nursing floor for the past 2 days. A fecal management system (FMS) has been in use for the past 15 days due to the patient's decreased level of consciousness and use of lactulose to treat elevated ammonia levels. Nursing staff reports that the patient has been constantly oozing liquid brown/yellow stool which has been partially but not fully managed by the FMS until it fell out of the patient completely early this morning. The patient is arousable and follows commands, but groggy and only oriented to self. Upon assessment, it was noted that the pad underneath the patient was saturated. Non-blanchable erythema was noted on the upper posterior thighs and scattered papules with satellite lesions were noted on the perianal area. The patient has moderate rectal tone with no obstruction and is therefore still appropriate for use of a FMS. A new FMS was placed, and the ballon was filled with sterile water until the green indicator popped at 45 mls. The tube was gently pulled back until resistance was felt and the tube was placed in a manner to promote drainage towards the bag without any kinks. Due to limited mobility, impaired skin integrity, and urinary incontinence, a Bard Purewick Flex female external urinary catheter was placed to direct urine away from the patient's skin. Miconazole powder was applied to areas of noted lesions for treatment of suspected secondary candidiasis infection. Superficial skin loss was noted in areas of non-blanchable erythema. A stage 2 HAPI was added to this patient's record and orders for turning every 2 hours using positioning wedges were ordered. An order for a low-pressure mattress with low air loss (Stryker IsoFlex LAL) was also placed as surface support for PI prevention and treatment. Coloplast Triad lotion was applied over areas of skin loss. Upon review of the patient's Braden score from this morning, a few of the sub-scores (moisture, mobility, and friction/shear) were called into question. A discussion on criteria for each Braden sub-score was held with nursing staff. Due to the patient's current mentation, education is not appropriate at this time. WOC nursing reached out to this patient's case manager for expected discharge planning, including potential caregivers at discharge to be included in future education sessions. The use of a FMS is indicated due to the patient's constant liquid stool output from lactulose. The patient has 14 days remaining in the 29-day window for FMS use. WOC nursing reached out to the primary physician for this patient to discuss any expected decrease or cessation of lactulose to help with FMS discontinuation. WOC nursing will follow up weekly with this patient while she remains in the hospital for reassessment and adjustments to the care plan as the patient's condition changes.

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?

This is a complex patient incorporating aspects of both W + C nursing in addition to all the other medical

complications. In addition, there is the possibility for a failure from the nursing staff that needs to be addressed, making staff education as important as developing a plan of care for the patient.

Reviewed by: _____ Date: _____

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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	✓	
Thoughts Related to Visit:		
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	