Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Kyle Aniol Day/Date: 11/9/25

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

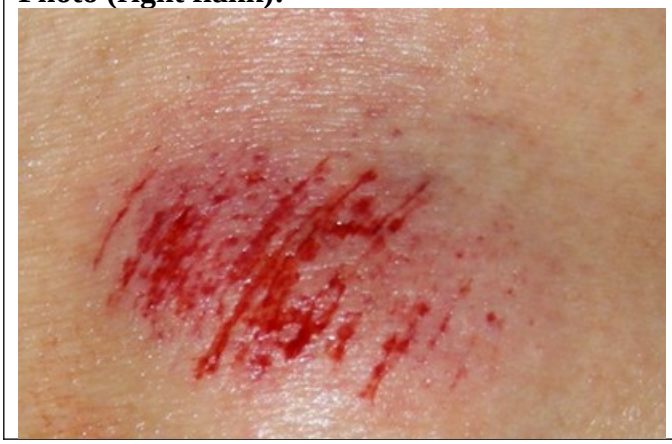
WOC nurse consulted by primary ED nurse due to concerns for red skin on buttocks and perineal area after arriving in urine-soaked brief.

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?

With the limited background information and poor orientation of the patient, I would have contacted the long-term care facility to try and obtain more medical history. As for the patient assessment, it seems to be complete but there are some areas that call for more follow up. The vital signs are stable but could be indicating infection. Labs are pending so I assume that basic blood work and a urine analysis were completed. The right flank wound should have been treated with an antibiotic ointment due to the nature of the wound. The patient is incontinent, disoriented, and appears unkept; there is a chance that the patient contaminated the wound when scratching. A dressing also needs to be placed over the wound to prevent further irritation. The groin and buttocks also need intervention to protect the skin from further breakdown. Recommending gentle cleansing of the skin with Dimethicone wipes, allow time to dry, then applying a layer of clear moisture barrier ointment to the affected skin, and leave open to air. Do NOT cover with briefs or diapers, USE moisture wicking incontinence pads.

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)

Wound Care- Right Flank
Change dressing weekly, and when transparent dressing is peeling or soiled
Wash the area with wound cleanser, allow time to dry
Apply a thin layer of Medihoney to wound surface
Place a nonadherent dressing over the wound
Use Tegaderm transparent film to secure dressing to skin
Keep dressing dry, avoid direct contact with water
Tape an ABD pad over the entire dressing if the patient attempts to peel or scratch the Tegaderm film

Braden Interventions
Use dimethicone wipes after episodes of fecal incontinence and apply a thin layer of clear moisture barrier ointment to erythematous skin.
Implement use of TruVue heel protector boots in bed. Boots should be on for 4 hours, off for 4 hours. Assess heels at least once per shift.
Implement use of low air loss mattress.
Do not use diapers or briefs on the patient, instead place moisture wicking incontinence pads under patient.
Implement Q2 turns using the TAP wedge system (left, right, supine).
Assess the skin underneath external catheter daily. Ensure skin is clean and dry before reapplying.

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:

The patient is being seen for an initial visit in the ER. Wound care was consulted for evaluation and management of apparent MASD to the buttocks, groin, and inner thighs, along with a partial thickness wound to the right flank. Per report, the patient is an 89 y/o male oriented to self only with dementia, non-ambulatory and non-verbal, requires feeding assistance, diabetic, and has a history of both urinary and fecal incontinence. On assessment, the patient is pleasant and able to follow commands, but continues to scratch at wound despite education. The right flank wound is bright red with mild erythema surrounding, partial thickness, and appears to be from scratching. Recommending Medihoney for moisture and antimicrobial properties, covered with a non-adherent dressing and Tegaderm transparent film. On assessment, MASD is present on the low back, buttocks, and inner thighs. Skin is excoriated, erythematous, but blanchable. Fecal incontinence present during assessment, characterized as brown, liquid stool oozing. Recommending cleansing the skin with dimethicone wipes and applying an ointment barrier to the affected areas. Will reassess need for fecal diversion after consulted providers assess patient. Continue use of external catheter for urinary incontinence, assess skin under device daily.
Consult PT/OT for weakness and debility.
Consult colorectal service for further evaluation of chronic incontinence.
Consult dietary for management of nutritional intake.

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?

My goal in choosing this case study was to identify appropriate interventions in the management of fecal incontinence. All encompassing management includes diverting and/or improving the incontinence, treating skin irritation or infection, and preventing skin breakdown. I think I met this goal as all the issues related to incontinence were addressed, along with other Braden interventions to promote skin health.

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	✓	