Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Courtney Segovia Day/Date: 12/7/25

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.

<table>
<tr><td>Chart Review/History</td><td>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 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:
<table>
<tr><td>Sensory Perception</td><td>1</td></tr>
<tr><td>Moisture</td><td>3</td></tr>
<tr><td>Activity</td><td>1</td></tr>
<tr><td>Mobility</td><td>1</td></tr>
<tr><td>Nutrition</td><td>1</td></tr>
<tr><td>Friction/Shear</td><td>1</td></tr>
<tr><td>Total</td><td>8</td></tr>
</table>

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</td></tr>
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<table>
<tr><td>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
<table>
<tr><td>Sensory Perception</td><td>4</td></tr>
</table>
</td></tr>
</table>

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:

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 Data:

- Past medical history
- Past surgical history
- Home medications
- Platelet count
- Recent history of bowel surgery, anal/rectal injury, large hemorrhoids, anal/rectal tumor, anal/rectal mucosa impairment (these are all contraindications to FMS).

Treatment Recommendations:

- Please see WOC RN plan of care below.

Consults:

- GI: Consider reconsulting GI given ongoing hepatic encephalopathy despite medical management.
- Infectious Disease: Consider consulting infectious disease for HSV/VZV if suspected candidiasis does not improve or worsens with antifungal treatment.
- Addiction Medicine/Substance Use Navigator (when hepatic encephalopathy improves/resolves and patient is able and willing to participate)
- Nutrition: Consider consulting nutrition for optimization of protein/calorie intake given liver disease. Patients will liver disease are at high-risk of protein/calorie and micronutrient deficiency. Additionally, the presence of candidiasis may correlate with hyperglycemia.
- Social work: Consider consulting social work for social support and SUD treatment.

Education:

- Patient is unable to engage with WOC RN education due to grogginess. Reassess appropriateness of education after hepatic encephalopathy improves/resolves.
- I educated care team on the importance of appropriate cleansing and moisture barrier cream application, moisture management, and patient repositioning.

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)

WOC RN Plan of Care

- Per WOC RN assessment, the patient does not have any contraindications to Convatec FlexiSeal Fecal Management System (FMS).
- Please reinsert FMS according to facility policy for continuous liquid stool management. FMS requires provider order and, at some facilities, the provider must perform digital rectal assessment prior to ordering.
- Apply topical antifungal to perianal/inner thigh papular lesions (e.g., miconazole or nystatin) twice daily — please request provider order.
- After each soiling: Please gently and thoroughly cleanse patient with pH balanced no-rinse perineal cleanser. Then apply CriticAid Clear Moisture barrier cream to protect from stool leakage.
- Reposition patient q2h and offload bony prominences utilizing AirTap patient repositioning system and wedges or Zflo gel fluidized positioned.
- Use a single layer of breathable incontinence pads and avoid layering linens underneath patient.

- Primary RN to perform complete skin assessment Q shift.
- Patient is at risk for thrombocytopenia given liver disease. Monitor FMS for rectal bleeding.
- FMS is not indicated for use for more than 29 consecutive days. Please notify provider if FMS when FMS has been in place 29 days.

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 RN Chart Note

Patient: 32-year-old female
Date of Service: 12/07/25
Reason for Consult: WOC RN consulted for reinsertion of fecal management system (FMS) and initial assessment of skin breakdown to buttocks/inner thighs.

History/Chart Review

- PMH: Unknown; admitted after field resuscitation. Suspected hepatic encephalopathy.
- ED Course: Found unresponsive at home; revived by EMS. Confused on arrival.
- Social History: Roommate reports frequent drug use, including recent methamphetamine use.
- ED Labs: K 2.4, HCO_3 19, lactate 2.9, myoglobin 113, UDS positive for opiates, ammonia 226, bilirubin 2.9.
- Imaging: CT/MRI head negative for acute stroke.
- ED Braden Score: 8 (Very high risk).
- Hospital Course: Intubated in ICU for impending airway compromise. Now transferred to medical unit x2 days. FMS in place for 15 days, recently dislodged.

Current Medications Relevant to WOC Care

- Sodium Bicarbonate 650 mg PO BID
- Rifaximin 550 mg PO BID
- Lactulose 20 g/30 mL PO q6h

Assessment

- Level of Consciousness: Awake, alert; oriented to name; groggy; follows commands.
- VS: T 99°F, HR 92, RR 26.
- Interview: Limited due to patient’s grogginess.
- Braden Score (AM): 15 (mild risk).

Sensory Perception	4
Moisture	3

Activity	1
Mobility	3
Nutrition	2
Friction/Shear	2
Total	15

Skin / Wound Assessment

Location: Buttocks and inner thighs
Type: Moisture-associated skin damage (MASD) with perianal candidiasis-like presentation
Appearance:

- Tissue loss: Superficial
- Size/Shape: Scattered raised papules in perianal area with satellite lesions
- Wound bed: Pink
- Exudate: None
- Odor: None
- Undermining/Tunneling: None
- Edges: Attached
- Periwound: Non-blanchable erythema to buttocks and thighs
- Moisture exposure: Buttocks and pads heavily soiled with constant liquid brown/yellow stool
- Pain: Unable to rate; grimaces with cleansing and verbalizes discomfort
- Rectal Vault: Moderate rectal tone; no stool impaction
- Continence: Ongoing liquid stool leakage; occasional urinary incontinence

Interventions Performed

- I cleansed the area gently and thoroughly with pH-balanced no-rinse cleanser.
- I applied moisture barrier product to protect skin from continued stool exposure.
- I evaluated candidiasis-type rash pattern; notified primary RN and first contact provider.
- I reviewed appropriateness of FMS reinsertion.

Education Provided

- I discussed need for physician follow-up regarding ongoing stool management, risk of skin breakdown, liver-related encephalopathy, and substance use considerations.
- I reinforced the importance of moisture management, repositioning, and skin protection with care team.

- I deferred patient education given patient unable to fully engage due to grogginess.

Recommendations

- If not contraindicated, please reinsert FMS for continuous liquid stool management. FMS requires provider order and, at some facilities, provider must perform rectal assessment.
- Apply topical antifungal to perianal/inner thigh papular lesions (e.g., miconazole or nystatin) twice daily — please request provider order.
- Apply CriticAid Clear Moisture barrier cream with every soiling.
- Reposition q2h and offload bony prominences utilizing AirTap patient repositioning system and wedges.
- Use one layer of breathable incontinence pads; avoid layering linens.
- Consider the following consults:
    - GI: ongoing hepatic encephalopathy, stool volume
    - Infectious Disease: if candidiasis worsens or for evaluation of possible substance-related infection risk
    - Addiction Medicine/Substance Use Navigator (when patient able to participate)
    - Nutrition: for optimization of protein/calorie intake given MASD risk
- Primary RN to perform complete skin assessment Q shift.

Plan

WOC team will follow-up for progression of MASD, response to moisture management, and stool containment needs.

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?

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	✓	