Cleveland Clinic

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

**Virtual Journal Entry with Plan of Care & Chart Note**

Student Name: Mara Michalski  Day/Date: 2/3 1/1/26

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.

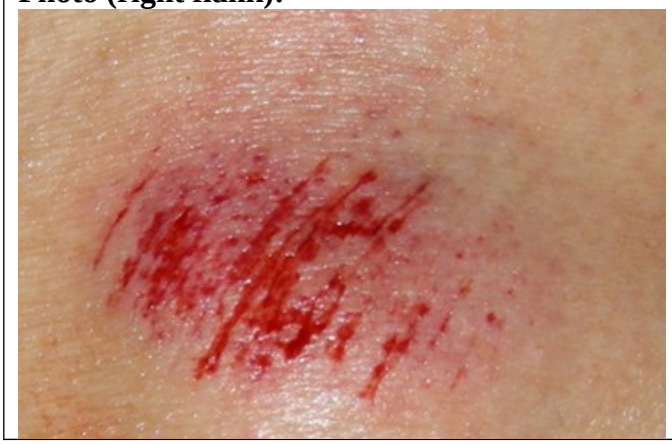
**Assessment/encounter:**
Prior to this visit, nursing placed external urinary catheter and connected to gravity drainage. Draining yellowed colored urine without sediment.
*LOC*: Non-verbal and follows commands. Pleasant, disoriented, cooperative.
*VS*: Temperature: 99.9F, Pulse: 102, Respirations: 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?**

First, I would contact the facility to receive a full list of his medications and why he is taking them. His mental status change may be due to a UTI so it is important, if possible to see what medications he is taking before starting him on other medications. Since it states the patient is itching, the excoriation may be caused by that and therefore an antihistamine or topical steroid cream may be ordered. Since the patient is nonverbal, it is important that staff uses a FACES pain scale when addressing patients pain . I would inquire how long the patient has had loose stool for and send a stool and urine sample to rule out infection. I would also switch the patient to an external urinary continence device that is hooked up to suction such as a Primafit to help prevent urine from pooling against the penile skin and causing breakdown. The patient should also have a nutrition consult to ensure that patient is receiving proper nutrients and fiber to help bulk the stool. The patient needs to be repositioned every 2 hours to prevent pressure ulcer formation, a slide sheet to be used when transferring patient to the stretcher, and assisted to the chair for meals. Due to patients increased temperature, tachycardia, and increased respirations, I would order labs to check for increased WBC, and dehydration. A CBC, CMP, along with blood glucose and A1C should be ordered. These labs are also

important because uncontrolled diabetes along with abnormal kidney function can cause patients to have pruritus.

**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. Collect clean catch urine and stool samples
2. Obtain CBC, CMP, blood glucose, and A1C labs
3. Apply external incontinence device that is to wall suction such as Primafit and change every 12 hours or as needed if soiled.
4. Turn patient every 2 hours for pressure injury prevention and assess for incontinence and transfer patient to chair for meals if tolerated.
5. cleanse patient with every incontinence episode with pH balanced soap and pat dry
6. Apply light layer of zinc oxide ointment to protect skin from breakdown every 24 hours or after incontinence episodes
7. consult dietary to ensure patient is on a nutrient dense diet to promote skin healing and ensure diabetes is controlled
8. use absorbent pads under patient, not briefs unless patient is being transferred to a procedure such as x ray and it is for short periods of time.
9. transfer patient to p500 pressure redistribution bed since the patient is at risk for skin breakdown with a Braden score of 14.
10. After cleansing, placed duoderm cut to size on wound bed and change every 72 hours or as needed if soiled with stool.
11. Use slide sheets when transferring patient to chair or stretcher to avoid shear and friction
12. consult PT/OT to help establish patient mobility baseline and help improve strength.
13. Reach out to primary team to inquire about patient starting an antihistamine for itchiness and notify primary provider of tachycardia, respirations, and temperature.

**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 consult for patient with incontinence associated dermatitis, noted excoriation, and altered mental status. Patient has a history of being nonverbal, non ambulatory, AFIB, CAD, diabetes, and dementia. Upon assessment, the patient is actively stooling, and a care plan for pressure, moisture management, and nutrition is needed. The patient should be transferred to a P500 pressure redistribution bed and also repositioned by staff every 2 hours to avoid pressure injury and assess for incontinence. The patient was cleansed with pH balanced cleanser and zinc oxide cream applied to the perineal area to prevent skin breakdown. A duoderm was placed on the noted excoriated area and is to be changed every 72 hours or as needed if soiled. Absorbent

pads were placed below patient and are to be changed when soiled. Avoid using briefs unless patient is being transferred to a procedure or working with physical therapy. A external incontinence device (Primafit) was placed on the patient and attached to wall suction and should be changed every 12 hours or as needed if soiled. A stool and urine sample was taken to rule out CDIFF or UTI. I request the patient's facility where he resides is contacted for a list of medications and full medical history. Orders for CBC, CMP, and A1C were placed to ensure patients diabetes is under control and that kidney function is normal, which if not could be contributing to pruritus. Primary team was notified of pruritus to see if an antihistamine is appropriate and also notified of Vitals of temp 99.9, HR 102, RR 26. Labs drawn to indicate infection and urine, and stool sample sent to rule out infection. Dietary consulted to ensure patients diabetes is managed through food and that the patient is receiving proper nutrients, along with increasing fiber to help bulk the stool. PT/OT consulted to help establish a patient mobility baseline and help patient with strength and mobility. If the patient's stool is not bulked after dietary changes, then a fecal management device may be considered.

**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 because the patient with this background is frequently seen in the hospital setting and outpatient setting as well. There could be a wide range of reasons why the patient is itching his skin and since he is non verbal we need to know the tests and labs to check to help rule out and find the cause of the issue. There could also be a wide range of reasons why the patient is having loose stool, so we should start with finding the root cause such as testing the patient for cdiff, UTI or other infections. My goal was to treat this patient holistically and consult and work with other members of different service teams to make sure this patient receives the proper care, along with preventing further skin breakdown or pressure injuries as a WOCN.

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 | ✓ | |