Daily Journal Entry with Plan of Care & Medical Record Note

Student Name: Date/hours:

Directions: ***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 you are acting as a nurse specialist;*** select one patient each clinical day and complete ***plan of care and chart note.*** This assignment should be WOC focused, and approached as both patient documentation and critical thinking development. Using a holistic WOC nursing approach combined with critical thinking strategies, complete each section of the document. Give careful consideration to how the patient was assessed, the problems, and the rationale behind the plan of care, and provide thorough documentation on the patient encounter. Once you have completed the form, save the document by clinical date and preceptor, and submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox by no later than **48 hours** following the clinical experience day.

Today's WOC specific assessment. ***Include pertinent past medical & surgical history and medications.***	**PMH:** 53 F with past medical history of GERD, HTN, and past cigarette smoker (2ppd, quit 20 years ago). Chief complaint of urinary frequency. Daytime frequency is every 30 minutes with nocturia 4-5 times a night with no enuresis. Oral fluid intake is two Venti cups of coffee from Starbucks per day, 1-2 8oz glasses of water per day and 3 shots of Tequila per day. She denies stool trapping, fecal incontinence and pelvic prolapse. **Surgical history:** Removal of ectopic pregnancy 1985 Tubal ligation 1999 Repair of right inguinal hernia 2009 **Medications:** Norvasc 5mg PO daily Gabapentin 300mg PO daily Flexeril 10mg PO daily

Write a comprehensive and understandable medical record note for the medical record for this patient encounter.
Be sure to include specific products that were used/recommended for use:

WOC Referral for: urinary frequency

PMH: 53 F with past medical history of GERD, HTN, and past cigarette smoker (2ppd, quit 20 years ago). Admitted to the hospital for influenza A and presents as a WOC referral with chief complaint of urinary frequency.

Assessment: Patient agreeable to visit and assessment. Abdomen is soft, nontender, nondistended with no palpable masses and no obvious hernias are present. External genitalia with no obvious masses, rashes or discoloration. The anus and perineum are normal. No

visible prolapse. Daytime urinary frequency is every 30 minutes with nocturia 4-5 times a night with no enuresis. Oral fluid intake is two Venti cups of coffee from Starbucks per day, 1-2 8oz glasses of water per day and 3 shots of Tequila per day. She denies stool trapping, fecal incontinence and pelvic prolapse. The patient was asked to void and voided 200mL and then after sterile preparation a 14 Fr catheter was inserted into the bladder with a post void residual of 5mL. Patient with urinary frequency likely due to overactive bladder. Patient main complaint is that she drives for Uber and has to pull over during rides to urinate. Patient states otherwise her urinary frequency does not impact her quality of life. She states that she does not use pads and does not have leakage of urine into her underwear. She has no mobility issues and is not overweight. Upon review of her a chart a urinalysis two days prior was negative for urinary tract infection.

Teaching:

1. Fluid and behavioral modifications. Decrease coffee and alcohol intake. Decrease coffee intake to under 100mg/day.
2. Continue with smoking cessation
3. Fluid intake increase to 2L/day
4. Avoid constipation (no complaints of constipation now)
5. Urgency suppression: When you get the urge to urinate stop, squeeze your pelvic floor muscles 3-5 times, sit on a hard surface, deep breathing, distract yourself and wait for the urge to subside, then walk calmly to the toilet.
6. Bladder retraining: Keep a bladder diary of how often/when you void and how much you drink. Try to gradually increase the time in-between trips to the restroom, even if it's just delaying for a minute or two at first then gradually build up the time.

Patient response: Patient adamant about not changing fluid intake at this time. States "I need the coffee to keep me going and I need the alcohol to calm me down at the end of the day." Patient not aggregable to other stress relief measures (did not want to listen to options). Patient somewhat agreeable to drinking more water, made plan to have a reusable water bottle in her car that she can sip on as she drives for Uber. Patient agreeable to continue to not smoke. Patient states she will keep a bladder diary to track symptoms. Patient agreeable to medication and a referral to a urologist for further work up and medication prescription is recommended.

WOC Nursing Problem pertinent to this visit	**WOC Directive Plan of Care** **(Base this on the above data. Include specific products)**	**Rationale *(Explain why an intervention was chosen; purpose)***
1. Readiness for Enhanced Sleep related to willingness to trying things that do not affect her caffeine and alcohol intake. 2. Ineffective Health maintenance related to unwilling to decreases	1.Obtain a sleep history including bedtime routines, sleep patterns, use of medications and stimulants, and use of complementary medical practices for stress management and relaxation before bedtime. Based on assessment above, educate client on: establishing a regular sleep schedule, arising at	1. This was chosen because the client has refused all other previous recommendations and would prefer to fix their overactive bladder w/ a pill. Most clients are reluctant to change routines and habits believing that's what helps them though the

caffeine and acholic intake to increase her bladder control.	the same time every day, limiting caffeine and alcohol intake during the day and at bed time (This needs to be addressed and reinforced at every meeting), decreases caffeine use by ¼ throughout the day and alcohol use by ¼ too, lastly client will not eat large meals before bed. 2. RN will educate client on diuretics and the best way to decreases the amount of voiding will depend on making dietary changes over time. RN will educate client that alcohol suppresses the production of a hormone called vasopressin. This hormone is playing an important role in the regulation of water excretion and if not addressed will likely continue to contribute to further issues. RN will continue to reiterate teaching of: 2a. Fluid and behavioral modifications. Decrease coffee and alcohol intake. Decrease coffee intake to under 100mg/day. 2b. Continue with smoking cessation 2c. Fluid intake increase to 2L/day 2d. Avoid constipation (no complaints of constipation now) 2e. Urgency suppression: When you get the urge to urinate stop, squeeze your pelvic floor muscles 3-5 times, sit on a hard surface, deep breathing, distract yourself and wait for the urge to subside, then walk calmly to the toilet. 2f. Bladder retraining: Keep a bladder diary of how often/when	day. Instead of asking the client to quit cold turkey or reducing the intake by half the client may be willing to decrees incrementally. 2. This client is reluctant to change their routine and will require short and to the point educational teaching sessions. New slightly more complex information could be brought up w/ the client to help them understand what exactly is exacerbating the issue. After which a teach back session could take place allowing for the opportunity to follow up questions and concerns.

	you void and how much you drink. Try to gradually increase the time in-between trips to the restroom, even if it's just delaying for a minute or two at first then gradually build up the time. Client will follow up w/ all previously discussed appointments.	

What are the disadvantages of using this product(s)?	Collecting a PVR via a straight catheter should not be the first method chosen to collect this. To help prevent a blader infecting, the RN should use a bladder scanner to determine the PVR and report this to the MD.
What alternative product(s) could be used and why? (This is your opportunity to share your product knowledge and apply critical thinking)	To help prevent a blader infecting, the RN should use a bladder scanner to determine the PVR and report this to the MD.

Develop one learning goal for each clinical day, document that on this form then share your goals with your preceptor.

Were you able to meet your learning goals for today? Why or why not?	
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	This is another good area to learn more about how to interact w/ clients and help them understand why specific treatment plans have been chosen. Most clients are apprehensive to changes in their day to day lives, unless the RN can articulate the reasons why in an easy-to-understand fashion.

Care Setting: Hospital

Reviewed by: _____ Date: _____