Cleveland Clinic

R.B. Turnbull, Jr., M.D. School of WOC Nursing

Daily Journal Entry with Plan of Care & Chart Note

Student Name: Melissa Romeo Journal Completion Date: 3/4/23

Setting: _____ Acute Care __X___ Outpatient _____ HHC ____ Other _____

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, a mini case study has been provided. Including assessment information and the chart note. Using this information, develop a plan of care (POC) which directs care.

Do not change the information provided. The 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. Once you have completed the form, save the document by date and specialty. Submit to your Practicum Course dropbox for instructor review & feedback. See samples in course to assist you with this assignment.

Today's WOC specific assessment	**PMH:** 59 year old female with migraines, pelvic organ prolapse and internal hemorrhoids. Previous urodynamic testing showed normal bladder capacity and compliance. Cystoscopy showed no lesions and CT urogram showed no suspicious renal or urothelial lesions. **Surgical history:** No surgical history **Medications:** Hydralazine 25mg PO three times a day Prednisone 20mg PO three times a day Losartan 25mg PO three times a day

Chart note for the medical record for this patient encounter. Included is any physical assessment, interactions, and specific products that were used/recommended for use.

REASON FOR REFERRAL: Pessary exchange

PMH: Reviewed and negative for pelvic organ prolapse and internal hemorrhoids. Urodynamic testing insignificant with no lesions seen on Cystoscopy or CT urogram.

ASSESSMENT: Patient agreeable to assessment and exchange. Patient has a normal urethral meatus. No lesions, discoloration or swelling noticed in the perineal area. Patient reports she has been using the pessary for the last year and has it exchanged every three months. Patient has a Gellhorn pessary in place. She reports that this type of pessary has been working well for her but she wants to have surgery to correct her pelvic organ prolapse once her blood pressure is more controlled. Upon pessary removal there were no signs of lesions or

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ulcerations. No bleeding, no foul discharge noted.

TREATMENT PERFORMED: Patient laid flat on her back, knees bent and feet placed flat on bed. Ring forceps used to grasp the knob of the Gellhorn pessary, the concave end of the Gellhorn pessary rotated to release suction, Gellhorn pessary pulled downward, folded and then removed. The Gellhorn pessary was then cleaned with soap and water and rinsed clean. Before reinsertion the vagina was examined for any signs of lesions or ulcerations, of which there were none. The Gellhorn pessary was then reinserted by folding in half, applying lubricant to the edge of the Gellhorn pessary, inserted past the pubic symphysis and unfolded. The Gellhorn pessary was allowed to expand and form suction.

TEACHING PERFORMED: Follow up with provider in 3 months for pessary exchange and notify provider if any signs of infection (discharge, swelling, odor etc) are noted. Follow up with provider regarding prolapse repair.

PATIENT TOLERANCE: Patient tolerated well. After insertion patient denied any discomfort, was able to move without any pain or restrictions. Patient able to void after reinsertion with no difficulty. Patient states that she desires to undergo surgery for her prolapse after she is medically cleared by her primary care provider (she has high blood pressure for which she is on medication)

WOC specific medical & nursing diagnosis and concerns	**WOC Plan of Care (include specific products used)**	**Rationale (Explain why an intervention is chosen; purpose)**
Identify specific problems or concerns. "Risk" concerns should be incorporated into the plan for actual problems/concerns. Dysfunctional pelvic floor muscles related to pelvic organ prolapse ***NANDA diagnosis do not have to be utilized. Alternative examples to identify the problems/conditions: knowledge deficit, fluid/electrolyte imbalance, etc***	**Statements should be directive and holistic relating to the problem/concern.** -Follow up with provider in 3 months for pessary exchange -Notify provider if any signs of infection are noted: discharge, swelling, odor -Follow up with provider regarding prolapse repair	**Statements should explain why the intervention/directive should be followed. References are not required, unless utilized.** -The pessary will need to be exchanged every 3-4 months (Ermer-Seltun & Engberg, 2022). This can be done by the patient if they are able and willing to perform this action independently. If they are unable, the provider will remove the pessary, clean it with soap and water, and then replace it. If the patient is managing the pessary herself, the follow up visits can be every 3-6 months or up to one year. -The provider should be notified if any signs of infection are present such as discharge, odor or swelling. Other complications that can occur are epithelium abrasion, rashes, erosion, lesions, discomfort/pain, bleeding, inelastic vaginal tissue, introital fissure, pelvic pressure and

		dysfunctional elimination of bladder, bowel or both. If the physical exam findings are concerning, a 2-4 week pessary holiday may be indicated. If erosions are present, topical estrogen may be considered. If the patient has lesions that are non-healing after treatment, a biopsy may be considered. Fistulas can also occur but are considered to be rare and do not commonly occur when the patient is compliant and follows up at regular intervals. -There are 2 surgical interventions for repair or pelvic organ prolapse. This can be done abdominally or vaginally. Patients who have opted against or failed non-surgical treatment of pelvic organ prolapse are considered candidates for surgical pelvic reconstruction. The anticipated outcome of surgical repair is to renew bowel, bladder and sexual function and the anatomy of the vagina. This procedure can improve the patient's quality of life. Comorbidities such as diabetes, obesity, heart and pulmonary disease and the use of anticoagulants can increase the risks of surgery. The vaginal surgical method can be done laparoscopically, robotically, or open. The use of mesh for surgical repair can lead to complications that require future surgeries. Postoperatively, patients should avoid lifting objects greater than 10 pounds and vigorous exercise for 4 to 6 weeks. The patient should abstain from sexual intercourse for up to 8 weeks postoperatively. Constipation should be avoided as straining can cause stress and pressure on the healing vaginal incisions. Vaginal discharge that doesn't have an odor and slight spotting are normal postoperative findings. If the discharge and spotting is similar to the amount seen during menses, this should be

		reported. If symptoms of stress or urge urinary incontinence persist for 4 to 6 weeks postoperatively, this should be reported to the provider as this is not an expected outcome. After the postoperative pain and tenderness are improved, the patient should do pelvic floor muscle therapy. The patient should be educated on the difference between the Valsalva maneuver versus a normal pelvic muscle contraction as the Valsalva maneuver is not an effective method for strengthening pelvic floor muscles. The Valsalva maneuver can be harmful to the patient after surgical repair of pelvic organ prolapse.

Identify each WOC product in use/identified in POC. State at least one disadvantage of the <u>product.</u> Identify an alternative to the product. Alternatives should be from a different category or classification. In other words, what could be used if the product was not available?	**This section helps to communicate your product knowledge and critical thinking skills. Products should be available in the US.** Gellhorn pessary: Disadvantage- can be difficult to remove, intercourse is not possible. Alternative- ring pessary

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

What was your goal for choosing this mini case study? Were you able to meet your learning goal for today? Why or why not?	My goal was to learn more about pessaries. I met my goal.
What are your learning goals for tomorrow? **(Share learning goal with preceptor)**	My goal for tomorrow is to learn more about pelvic floor muscle therapy.

Reflection: Identify/describe thoughts related to the mini case scenario, anything	I would include pelvic floor muscle therapy in the follow up education if the patient is not already doing pelvic floor muscle therapy. A physical therapy consult may be

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you might have done differently, etc	warranted. Corrections 3/11/23 The pelvic organs are supported by the pelvic floor muscles. In the event of pelvic organ prolapse, as this patient is experiencing, pelvic floor muscle therapy can help to increase the function and support provided by the pelvic floor muscles (Ermer-Seltun & Engberg, 2022). Pelvic floor muscle therapy can decrease the symptoms of pelvic organ prolapse. Despite this, pelvic floor muscle therapy will not decrease the severity of the prolapse. Pelvic floor muscle therapy can also be used to prevent stress urinary incontinence and uterine prolapse, accelerate postpartum healing, and intensify feeling during intercourse (Engberg, 2022). To perform the exercises, the patient will contract or tighten the pelvic floor muscles (Callan & Francis, 2022). At the same time, they will work to keep the abdominal muscles relaxed. To start, this should be done three times daily for twelve weeks. Exercise plan: - 3 times daily - To contract pelvic floor muscles, tighten the perivaginal muscles and anal sphincter as if you are holding urine or stool. At the same time, do not tighten or contract the abdominal, inner thigh or buttock muscles. - Contract pelvic floor muscles 10 times in a row, holding each contraction for 3-5 seconds. Increase the length of each contraction up to 10 seconds as tolerated. Relax the pelvic floor muscles for 10 seconds in between contractions. - The exercises can be done lying, sitting, or standing. - If you are finding it challenging to contract the pelvic muscles without contracting the abdominal muscles, try performing the exercises leaning forward with arms against the back of a chair, table, or wall. - When you are able to hold each contraction for 10 seconds, consult with your physical therapist as the number of contractions may be increased at this time.

Reviewed by: _____ Date: _____

References

Callan, L. L., & Francis, K. (2022). Fecal incontinence: Pathology, assessment, and management. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 484-519). Wolters Kluwer.

Engberg, S. (2022). Stress urinary incontinence in women. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 213-236). Wolters Kluwer.

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Ermer-Seltun, J. M., & Engberg, S. (2022). Advance pelvic health considerations for women: (Part B) Pelvic organ prolapse and vesicovaginal fistula. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 253-276). Wolters Kluwer.

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