

Virtual Journal Entry with Plan of Care & Chart Note

 Student Name: Elisa Weil

 Day/Date: 7-22-24

 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	<p><u>Age/sex</u>: 68-year-old Male</p> <p><u>PMH</u>: Legally blind, osteoarthritis, obesity, HTN, DMII (controlled). Compound tibial fracture to left leg requiring surgery. Fracture sustained 3 weeks ago during a MVA where pt was a passenger.</p> <p><u>CC</u>: "New onset urinary incontinence"</p> <p><u>Meds</u>: Lisinopril 20mg PO daily, Metformin 500mg BID with meals, Percocet 5/325mg PO prn for pain</p> <p><u>Social hx</u>: ½ ppd. smoker, Recreational "4 or 5 beers to fall asleep"</p> <p><u>Labs</u>: None available</p>
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Assessment/encounter:

LOC: awake, alert, attentive

VS: Temperature: 98.6F oral, Pulse: 66, Respirations: 14, BP: 142/78, BMI: 29.5

Initial interview: Patient reports new onset urinary incontinence after discharge from surgery after MVA. He is non-weight bearing to left leg. Ambulates using crutches given to him by a friend. States he lives alone in a second-floor apartment but has been staying with a friend who lives in a flat with no stairs due to his crutches and mobility issues. Patient reports feeling need to urinate but is unable to get to the bathroom in time, especially at night. Expresses frustration at the situation, as he had a recent fall.

ROS:

Well-nourished appearing male, who appears stated age. No acute distress noted.

Skin color, texture, turgor normal. No rashes or lesions noted.

Alert and orient x 4, appropriate affect. Appropriately dressed for the season with blue jean overalls cut to accommodate his cast.

Respirations even and unlabored, clear to auscultation.

Heart sounds are normal
Abdomen soft and round. Active bowel sounds x 4 quadrants
Musculoskeletal active range of motion is grossly normal, arthritic joints noted to bilateral hands.
GU: Able to void normally into urinal at this visit.

Education: identify below

Suggested consults: identify below

Photo: N/A

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?

Several tests of this patient should be done starting with a urinalysis to determine if the patient has a urinary tract infection, blood, or glucose in the urine. It can also be used to assess if he has prostatitis. A voiding diary will help to establish a pattern of voiding as well as incontinence. I would also perform a post void residual to see if the patient is emptying his bladder with each episode of voiding. Urodynamic studies should be performed to assess bladder and urethral function. The patient's smoking and drinking habit need to be addressed. This patient is also legally blind and staying at a friend's home that is not as familiar to him as his own home, which may contribute to not making it to the bathroom in time.

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)

- Urinalysis
- Voiding diary to be obtained for a 3 day period.
- Post Void Residual
- Urodynamic testing
- Physical Therapy and Occupational Therapy evaluation
- Assessment of barriers in living space
- Smoking Cessation Program referral
- Alcohol prevention program
- Planned toileting schedule every 2-3 hours during the day.
- Urinal to be kept at bedside for nighttime voiding.

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 visit for 68 year old male with complaint of “new onset urinary incontinence.” Patient has a past medical history of DMII, osteoarthritis, legally blind, HTN, and obesity. Patient is 3 weeks post operative for a fracture to his left leg following a motor vehicle accident. The patient is non-weight bearing to the left leg and is currently ambulating with crutches given to him by a friend. The patient lives alone in an apartment on the 2nd story, however he is currently staying with a friend that lives in a flat without any stairs. The patient states he feels the urge to go to the bathroom but is unable to make it on time, especially at night. The patient is frustrated with his situation, as he has recently fallen.

The patient is a ½ ppd smoker and states that he drinks recreationally, “4 or 5 beers to fall asleep”.

Current medications include Lisinopril 20mg PO daily, Metformin 500mg BID with meals, and Percocet 5/325 mg PO as needed for pain.

The patient is alert and oriented x 4 with appropriate affect. The patient is well nourished and is dressed appropriately for the season. Skin color, texture, and turgor are WNL. No rashes or lesions noted. Respirations are even and unlabored and clear to auscultation. Heart sounds are WNL. Abdomen is soft and round with active bowel sounds in all 4 quadrants. Patient is non-weight bearing to left lower extremity, and osteoarthritis is noted to bilateral hands. The patient is legally blind.

Urinalysis obtained this visit with results pending. Patient was able to void without difficulty at this visit and post void residual was checked with 15mL remaining in bladder. Patient was instructed to keep a 3 day voiding diary to determine voiding pattern. Patient will return in 1 week for urodynamic testing and review of voiding diary.

Referral placed to home health agency for PT and OT evaluation. Included in the evaluations are barriers within the home environment such as placement of furniture and rugs.

Patient education included smoking and alcohol cessation with referrals to cessation programs. Patient also instructed on a scheduled toileting schedule. Patient will void every 2-3 hours during the day and set a reminder alarm during the night. Patient was given a urinal to keep at bedside for voiding at night. Patient was instructed to clean up immediately following episodes of incontinence to prevent skin breakdown. The patient verbalizes understanding of the education provided.

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?

As an inpatient nurse that has never worked an ambulatory center, I have had very little experience with continence patients other than MASD and voiding trials. I chose this case to give me a feel on what to expect

on the ambulatory side including assessing, planning, and follow up for the incontinent patient.

Reviewed by: _____ Date: _____

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> • Identifies why the patient is being seen 		
<ul style="list-style-type: none"> • Describes the encounter including assessment, interactions, any actions, education provided and responses 		
<ul style="list-style-type: none"> • Includes pertinent PMH, HPI, current medications and labs 		
<ul style="list-style-type: none"> • Identifies specific products utilized/recommended for use 		
<ul style="list-style-type: none"> • Identifies overall recommendations/plan 		
Plan of Care Development:		
<ul style="list-style-type: none"> • POC is focused and holistic 		
<ul style="list-style-type: none"> • WOC nursing concerns and medical conditions, co-morbidities are incorporated 		
<ul style="list-style-type: none"> • Statements direct care of the patient in the absence of the WOC nurse 		
<ul style="list-style-type: none"> • Directives are written as nursing orders 		
Thoughts Related to Visit:		
<ul style="list-style-type: none"> • Critical thinking utilized to reflect on patient encounter 		
<ul style="list-style-type: none"> • Identifies alternatives/what would have done differently 		
Learning goal identified		