

**Virtual Journal Entry with Plan of Care & Chart Note**
**Student Name:** Melinda Grace Taft
**Day/Date:** 07/23/2024

 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.**

<b>Chart Review/History</b>	<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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<p><b>Assessment/encounter:</b></p> <p><u>LOC:</u> awake, alert, attentive</p> <p><u>VS:</u> Temperature: 98.6F oral, Pulse: 66, Respirations: 14, BP: 142/78, BMI: 29.5</p> <p><u>Initial interview:</u> 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.</p> <p><u>ROS:</u> 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</p>
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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?**

- Since the crutches were gifted to the patient by his friend, I would assess for proper fit of the crutches. I would also assess the integrity of the axillary skin for signs of pressure and/or breakdown.
- I would inquire if the patient struggles to perform other ADLs besides toileting (bathing, toileting, etc.). The patient may require referral to a physical therapist and/or occupational therapist to assist him with rehabilitation and performing ADLs following his recent injury and fall.
- I would further explore the onset and characteristics of the patient's voiding pattern.
  - Is the patient only having these episodes related to not making it to the bathroom on time following the urge to urinate?
  - Does the patient experience urine leakage with activities that increase intraabdominal stress? (exercise, laughing, coughing, sneezing, changing position)
  - Is the patient ever able to suppress the urge to urinate when toileting is not convenient?
  - How many times, on average, does the patient urinate each day?
  - Does the patient ever feel like he does not completely empty his bladder?
  - Does the patient ever experience spontaneous leakage of urine that's not preceded by the urge to void?
  - Does the patient experience pain or discomfort when voiding?
  - Does the patient experience any post-void dribbling of urine?
  - Has the patient experienced any kind of voiding dysfunction in the past, prior to the MVA/leg injury?
- I would further review the patient's dietary intake, exploring what kinds of foods he commonly consumes and how much water/fluids [on average] he drinks per day. Through this, I can determine if the patient routinely consumes products that are irritating to the bladder [*besides alcohol, as stated above*]. The patient may require referral to a registered dietician to assist him with creating a healthy meal plan that will not cause irritation to the urinary system and promote healthy weight loss.
- I would inquire about the patient's bowel habits.
  - When is the last time the patient had a bowel movement?
  - On average, how often does the patient have a bowel movement?

- What is the consistency/quality of his stool?
- Does the patient ever use laxatives to facilitate bowel movements? If so, which kind(s) of laxatives, and how often are they administered?
- Based on the obtained vital signs, the patient is not demonstrating overt signs of infection or dehydration. However, I would obtain a clean catch urine sample for urinalysis.
- Relevant educational counseling:
  - smoking cessation
  - decreasing alcohol consumption
  - weight loss
  - dietary adjustments

**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)**

- **Complete a bladder diary and bring the completed log with you to your next appointment. Enter the following information into the provided template for five consecutive days:**
  - Time of void
  - Was it intentional (on toilet) or an involuntary loss of urine?
  - Amount of urine loss
    - Small: a few drops or small wet spot of urine
    - Moderate: several teaspoons/tablespoons of urine
    - Large: undergarments/clothing are saturated with urine
  - If involuntary, what preceded the episode?
- **Certain foods and beverages can irritate the bladder and contribute towards involuntary urine loss. Avoid or limit consumption of:**
  - Alcohol
  - Spicy foods
  - Carbonated beverages (cola, sodas)
  - Caffeinated beverages (coffee, tea)
  - Milk and dairy products
  - Food colorings and flavorings
  - Artificial sweetener
  - Chocolates
  - Citrus fruits/juices (orange, lemon)
  - Tomatoes, tomato-based products (ex. pasta sauces, soups)
  - Vinegar
  - Melons, cantaloupe
  - Pineapple, strawberries, plums, cranberries

*Suggested food/beverage substitutions:*

- Low acidic fruits: bananas, pears, apples, cherries, grapes/raisins, papaya, nectarines
- Grape juice, apple juice
- Herbal teas
- KAVA® (low-acid instant coffee)
- Low sodium popcorn/chips/pretzels
- Fresh vegetables with non-dairy dip
  
- **Establish a routine bathroom schedule:**
  - Limit fluid intake within 4 hours of going to sleep, and void prior to going to bed.
  - Use the restroom every 3 to 4 hours. You can set reminders, such as alarms on your cell phone, to use the restroom.
  - Take your time when voiding, and fully relax.
  - Promote daily bowel movements through increased water and fiber intake.
    - Consume 8 to 10, 8-oz glasses of water per day.
    - Consume high fiber foods, such as whole grains, beans, seeds, nuts, and vegetables.
  
- **Keep a hand-held urinal by your bedside for quick access during the night when you feel the urge to void.**
  - Clean the urinal with warm, soapy water after each use.

*Alternatively, keep a bedside commode in your bedroom for quick, convenient bladder/bowel emptying.*

  - DME
    - Male hand-held urinal: #PF06223, E0325
    - 3-in-1 bedside commode: #P7085-RB, E0163
  
- **Wear non-restrictive clothing that can quickly and easily be removed to use the restroom.**
  - Ex. Elastic-band shorts or pants; shorts/pants without zippers or multiple buttons
  
- **Pelvic Floor Exercises, 10 sets per day**
  1. Empty your bladder before beginning the exercises.
  2. Squeeze pelvic muscles as if trying to hold in gas, keeping the abdominal muscles, buttocks, and thighs relaxed.
  3. Hold the squeeze/contraction for at least 5 seconds.
  4. Release the contraction and completely relax the muscles. To help relax, take a deep breath through your nose, expanding your belly, and breathe out through your mouth.
  5. Repeat the series (contraction/relaxation) nine more times.
  6. Alternate performing these exercises in standing, sitting, and laying (supine) positions.
  
- **Referrals ordered by MD to physical therapy, occupational therapy, and registered dietician.**
  
- **DME prescription for male hand-held urinal and bedside commode entered into EHR by MD.**

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**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:

68-year-old male

PMH:

- Controlled type 2 diabetes mellitus, hypertension, osteoarthritis, legal blindness, obesity
- S/p compound tibial fracture d/t MVA
- Recreational alcohol consumption, ½ ppd smoker
- Medications:
  - Lisinopril 20mg PO, daily
  - Metformin 500mg, BID with meals
  - Percocet 5/325mg PO, PRN for pain

Initial visit for evaluation and management of new onset urinary incontinence. No family/friends/caregivers present to the clinic with the patient. The patient states that he is unable to reach the bathroom in time to void related to his recent injury, resulting in episodes of involuntary urine loss. Per the patient, it's "hard for [him] to get around and do things" because of his injured leg. The patient currently uses borrowed crutches to ambulate and states that they are "awkward" and "often hurt to use." Local skin assessment revealed dry, intact, and non-reddened skin to the axillae. In terms of nutrition and hydration, the patient reports primarily consuming fast food and microwavable frozen meals, as it is "easiest for [him]". In addition to "4 or 5 beers to fall asleep," the patient typically drinks 1 glass of water with medication administration and 2 cans of Coca-Cola® on a daily basis. On average, the patient has a bowel movement every two days. The patient does not report laxative use. The patient has not experienced urinary or fecal incontinence in the past. The patient does not experience urine loss with activities that increase intra-abdominal stress (coughing, laughing, sneezing, exercise, changes in position). The patient denies pain or discomfort when voiding. The patient does not experience involuntary urine loss without the sensation to void. The patient denies post-void dribbling and feeling bladder fullness after voiding. The patient is alert and oriented x4 and demonstrated intact, sharp cognition. The patient demonstrated appropriate dexterity with using a hand-held urinal to void. Based on the collected information, the patient is likely experiencing functional incontinence.

Clinician recommended keeping a hand-held urinal or bedside commode in his bedroom within close proximity for quick, convenient voiding, especially at night. The clinician introduced the patient to pelvic floor exercises, emphasizing how they support overall bladder functioning and can be implemented to help briefly delay/suppress the urge to void until it is more convenient. Clinician recommended establishing a routine to void every 2 to 3 hours and just prior to sleep. Clinician discussed keeping a bladder diary to record his voiding pattern and incidences of leakage. Throughout the day, clinician recommends wearing non-restrictive, easily removable clothing/bottoms that won't cause a delay in voiding [with removal]. Clinician provided counseling on smoking cessation; weight loss through gradual, attainable/realistic dietary changes; and reducing daily alcohol consumption to support genitourinary health. Clinician identified certain foods/beverages the patient commonly consumes that can be irritating to the bladder. Based on the patient's

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inadequate nutritional status, clinician recommended referral to registered dietician. Since the patient is having mobility issues and recently sustained a fall, clinician recommend referral to a physical therapist and an occupational therapist for rehabilitation. The patient was accepting of the provided information and suggested interventions. All questions were welcomed and answered during this time. The patient expressed motivation in “getting [his] health under control.”

Assessment and plan of care reviewed with MD. MD is agreeable to proposed plan of care. MD to enter referrals and prescription for DME into the EHR.

The patient will return to the clinic in 1 week for a follow-up appointment.

**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?**

During my practicum, I have not had the opportunity to care for a patient with functional incontinence. Many cases of bowel/bladder incontinence I have learned about or been involved with have been neurogenic in nature. I wanted to further explore management strategies for functional incontinence, especially with an older adult patient, as my primary experience in patient care has been with neonates and children.

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

CRITICAL ELEMENTS	Completed	Missing
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		
• Statements direct care of the patient in the absence of the WOC nurse		
• Directives are written as nursing orders		
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter		
• Identifies alternatives/what would have done differently		
Learning goal identified		



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