

Virtual Journal Entry with Plan of Care & Chart NoteStudent Name: Miranda Prawdzik Day/Date: 10/16/2024Setting: 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?

In the initial interview I may have gathered more detailed information about the incontinence episodes. For example, I would have asked specifically how many incontinence episodes the patient has a day/night, how often, and if there are any issues urinating when able to void in the toilet. Another thing I may have assessed in more detail is the patient's mobility or gait. The musculoskeletal assessment is stated above but limited. I may have assessed the patient's gait with the crutches and how the patient transfers from sitting to standing and vice versa. Other information I would have also gathered or questioned is if there are any fecal continence issues as well, or if bowel movements are regular.

Otherwise, I would have maybe gathered more social information about the patient. As the patient is legally blind, I would want to know how the patient gets around normally and what accommodations they use like a cane, tactile aids, or seeing eye dog. Another question could be what percent of vision is still intact.

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)

- Continue use of mobility aids (crutches or walker) for ambulation and transfers
- Consult PT/OT for mobility aid assessment and recommendations, as well as baseline mobility assessment
 - Consult for rehabilitation course of treatment for left leg fracture
- Initiate use of incontinence collection devices to the level of patient comfort
 - Absorbent briefs during day and night for collection of leakage as needed
 - Absorbent pads in bed at night
- Initiate use of toileting accommodations
 - Bedside commode or urinal, within reach while at rest
- Ensure safe physical environment
 - Clear walking pathway through common areas and to the bathroom
 - Keep common areas free of clutter, rug edges taped down, adequate lighting

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- Maintain daily fluid intake at 8-10 (8oz) glasses spread throughout the day
- Decrease or eliminate alcohol intake
- Smoking cessation, offer alternative nicotine products as needed for support (gum, patch)
- Referral to addiction medicine services for substance abuse management and cessation, counseling
- Referral to social work and disability services to aid individual in transition back to independent living
- Initiate scheduled toileting at regular intervals, Q1-2 hours
- Maintain good blood glucose control/type 2 diabetes control
 - Continue oral hypoglycemics
 - Routinely monitor blood glucose levels through finger stick blood test (ACHS)
 - Obtain annual hemoglobin A1C blood measure

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:

This patient is a 68-year-old male with a past medical history of osteoarthritis, obesity, type 2 diabetes well controlled, hypertension, legally blind, and a compound left tibial fracture (2024) following previous MVA. The patient also endorses a fall history within the last month while at home. Only pertinent surgical history is left tibial compound fracture reduction and fixation (2024). The patient presents today for an initial visit regarding a complaint of new onset urinary incontinence.

The patient's chief complaint upon assessment: new onset urinary incontinence following discharge from tibial fracture surgery, continence issues complicated by new decreased mobility, and being unable to reach bathroom in time to void. The patient states he feels the urge to urinate and endorses being able to void voluntarily with no issue. The patient complains of difficulty reaching bathroom in time to void in toilet, with increasing difficulty to reach bathroom in sufficient time during the night. The patient endorses new decreased mobility following recent surgery, as the patient is to remain non-weight bearing to the left lower extremity.

Physical Assessment:

- Patient seen in home for initial visit of new onset urinary incontinence
- Patient alert, oriented, and follows commands. Patient with appropriate affect, answers questions fully and appropriately. Upon assessment, pt sitting upright in a chair dressed for the weather in jean overalls cut to accommodate leg cast.
- Patient appears well nourished, no distress noted at time of assessment. Patient endorses feeling frustrated with current condition, but ready to discuss and work with WOC team.
- The patient is legally blind, the percentage of vision intact and aids used not determined at this visit.
- Patient skin intact, normal coloring and turgor. No evidence of skin breakdown noted.
- Patient on room air with even, unlabored respirations. Clear breath sounds.
- Heart sounds normal.
- Abdomen rounded and soft to palpation, no tenderness. Normal bowel sounds.
- Active range of motion in all extremities, patient non-weight bearing to left lower extremity. Current use of

crutches for ambulation. Patient reports mobility issues, decreased mobility with ambulating and transfers. Endorses recent fall history in home.

- Arthritic joints noted to bilateral hands.
- Patient endorses frequent incontinence episodes. The patient states feeling the urge to urinate but being “unable to get to the bathroom in time, especially at night”.
- Patient is able to void voluntarily, normally into urinal at the time of this visit. Urine characteristics WNL.
- No verbal complaints of pain at time of visit.

Social History:

- Patient is currently staying at a friend’s house due to mobility issues, but normally lives alone. Patient’s home is a two-story home with stairs, patient is unable to climb stairs at this time.
- Patient is a current, every day cigarette smoker, 0.5 ppd.
- Patient reports recreational alcohol use, “4 to 5 beers to fall asleep”
- Legally blind

Current Medications:

- Lisinopril 20mg tablet PO daily
- Metformin 500mg tablet BID with meals
- Percocet 5/325mg tablet PO PRN for pain

Most Recent Lab Values/Tests/Vitals:

- No lab work or testing performed at time of visit
- Most recent vital signs are as follows:
 - Temperature 98.6F, HR 96, BP 142/78, RR 14
- Most current calculate BMI of 29.5

Reviewed Patient Continence Education:

- Utilization of incontinence collection devices and accommodations aids
 - Use of bedside commode or urinal during the night
 - Use of absorbent brief during daytime and nighttime as needed, per patient comfort
- Lifestyle modifications
 - Decrease overall alcohol intake, decrease alcohol intake before bed
 - Smoking cessation
 - Maintain adequate daily fluid intake
- Utilization of mobility aids
 - Continue use of crutches or a walker
 - Clear pathway to the bathroom or toilet aids, no clutter or rugs or tripping hazards
 - Loose fitting clothes that are easy to remove
 - Wear well fitted, closed toe footwear with ambulation, activity, exercise
- Timed/scheduled toileting
 - Void at more regular/frequent intervals to avoid rushing to the bathroom, Q1-2 hours
 - Frequency decided by patient and normal urination schedule

Recommendations:

Continued use of mobility aids for ambulation and transfers.

Utilize incontinence collection devices and toileting accommodations as needed.

Initiate lifestyle and diet modifications to decrease incontinence symptoms.

Initiate scheduled toileting time at pre-determined intervals.

WOC home health team will follow up routinely with patient, every other week.

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 in choosing this case?

I chose this specific virtual case as I was unable to assess any patients during in-person clinical time with functional incontinence as the primary issue/complaint. I feel I am least familiar with this form of incontinence as well; I feel it is less discussed than other types of incontinence. I feel I was able to meet this goal of learning more about functional incontinence as I was able to read about this specific patient situation and was able to review information about functional incontinence in my notes and textbook. I think I have a better understanding of how functional incontinence affects an individual and how it is treated/managed.

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		