Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Miranda Prawdzik Day/Date: 10/17/2024

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.

Chart Review/History	*Age/sex*: 78-year-old Female *PMH*: hypertension, COPD, dyslipidemia, diabetes, obesity, osteoarthritis, and GERD. Vaginal deliveries x 3; in 1970, 1972, and 1975. Mixed urinary incontinence (2021 *CC*: Urine leak when sneezing or coughing, referral for pelvic muscle strength training. Has tried to manage symptoms. Referred to the outpatient continence clinic a few months ago for pelvic muscle strength training to improve bladder control. Patient is new to this health system and no previous urological records available. *Meds*: Lisinopril 20mg PO daily, Rosuvastatin 20mg PO daily, Metformin 500mg BID with meals, Tylenol 325mg PO prn *Social hx*: remote former social smoker, no ETOH or illicit drug use *Labs:* None Relevant

Assessment/encounter:
LOC: awake, alert, attentive
VS: Temperature: 98.6F oral, Pulse: 84, Respirations: 16, BP: 132/74, BMI: 33.1

Initial interview: Patient reports attempting Kegel exercises. Continues to leak urine when sneezing or coughing. Urgency issues experienced in the past are much improved. Drinks one caffeinated beverage (coffee) first thing in the morning. Avoids caffeine during the rest of the day. Reports an active lifestyle to "manage weight". Independent in ADLs. Follows ADA diet.

ROS: negative

GI/GU: WNL No prolapse or hernia noted.
Able to demonstrate Pelvic floor muscle training exercises as per previously directed to her by an unnamed provider. Holds for 5 seconds, releases for 30 seconds. Does 10 repetitions. States she repeats these daily.

Reports having been instructed on a leg raise and pelvic thrust exercise. Does not perform because she cannot remember the steps.

Education: PFME and other, 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?

Something I may have done differently is gather more information/background on how the patient was "managing symptoms" at home. What was being done and what products were used? The patient mentions Kegel exercises, but what else was being actively done? Another thing I would have done differently in the data collection is ask more about the incontinence episodes (how often, what time of day, what precedes the accidents, etc.).

In the treatment aspect, it is good the patient is already following ADA diet and trying to remain active. Also, it is good the patient is familiar with Kegel exercises. However, instructions should have been given to slowly increase the time the muscle contraction is held. It also should be explained that more intense exercise and weight management may be needed to lessen urinary symptoms.

Overall, there is just a lot of information I would have inquired about. For example, the patient's current diet, daily fluid intake, what she does to stay active, more information on incontinence episodes, or what current methods are used to manage symptoms. I also would like to obtain a new/current set of lab work and urine sample.

For education, I would certainly touch on PFME, completing an incontinence diary, the importance of sticking to the ADA diet and limiting caffeine, weight management, diabetes management, adequate fluid intake, and possible urge suppression.

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)

- Instruct patient to complete incontinence diary, prior to next follow-up appointment.
- Consult for urodynamic testing for evaluation of overactive bladder/bladder non-compliance.
- Obtain lab work, urinalysis, and urine culture.
- Instruct patient to schedule follow-up appointment in 2-4 weeks, after completing testing and bladder diary.
- Consult for initiation of pelvic floor muscle training.
    - Perform exercises at home as instructed.
    - Perform exercises in a supine, sitting, and standing position if patient is able.

- Instruct the patient to isolate pelvic floor muscles by squeezing like they would to hold in urine/stool or gas, while keeping all other external muscles relaxed. A patient can also be instructed to squeeze like they are trying to pull inwards from the vagina.
- Instruct patient to squeeze for 10 seconds then relax for 10 seconds.
- Muscle contractions and relaxations should be performed at least 10 repetitions per day.

- Instruct patient to practice urge suppression exercises.
  - When the urge to urinate is felt, direct the patient to relax with deep breathing followed by 5-6 strong pelvic floor muscle contractions (see above PFME).
  - After deep breathing and muscle contractions, the patient should use mental distraction while on the way to the toilet (positive self-talk, humming or singing, imagery)
- Utilize incontinence containment devices as needed, to patient's comfort, during day and night.
  - Absorbent briefs, wearable absorbent padding, absorbent pad in bed
- Maintain daily fluid intake at 8-10 (8oz) glasses.
- Limit caffeine intake to less than one cup caffeinated coffee per day. Continue to avoid caffeine intake after midday. Avoid consuming coffee on an empty stomach/upon waking.
- Perform 30-60 minutes of moderate-intensity physical activity/exercise per day.
  - Consult PT/OT as needed for recommended activity/exercises for patient mobility level.
- Maintain good blood glucose control/diabetes management.
  - Continue ADA diet as instructed by nutritionist.
  - Routinely monitor BG through finger stick blood tests
  - Monitor hemoglobin A1C annually.

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:

The patient is a 78-year-old female with a past medical history of hypertension, dyslipidemia, COPD, diabetes, obesity, GERD, osteoarthritis, and diagnosed mixed urinary incontinence (2021). The patient has no pertinent surgical history. The patient does have a history of 3 successful vaginal deliveries (1970, 1972, 1975).

The patient presents for an initial visit with the outpatient continence clinic. The patient is new to this health system and no urological records available for review. History was obtained from the patient. The patient was referred to the clinic a few months prior for management of mixed urinary incontinence and initiation of pelvic floor muscle training for bladder control. The chief complaint upon assessment is urine leakage with coughing and sneezing, as well as urgency issues. The patient states she has been trying to manage symptoms at home, unsuccessfully. The patient also endorses attempting daily Kegel exercises at home, instructions given by a previous, unknown provider.

Physical Assessment:

- Patient seen in outpatient clinic for management of mixed urinary incontinence and PMFT education.
- Patient alert, oriented, and follows commands. Patient attentive and receptive to education and conversation.

Normal affect.
- Review of systems deferred.
- GI/GU visual and physical examination performed, WNL.
- No evidence of pelvic prolapse or hernia.
- Patient endorses urinary incontinence with stress and urgency, leakage with coughing and sneezing. Reports urgency issues have improved in the last few months.
- No fecal incontinence or bowel issues reported at this time.
- No mobility concerns, patient verbalized being independent with all ADL's.
- No verbal reports of pain at time of visit.

Social History:
- X3 vaginal deliveries
- Former smoker, unknown ppd
- No alcohol or drug use

Current Medications:
- Lisinopril 20mg PO once daily
- Rosuvastatin 20mg PO once daily
- Metformin 500mg BID with meals
- Tylenol 325mg PO PRN

Most Recent Lab Values/Tests/Vitals:
- No testing or lab work performed at the time of visit.
- Most recent vitals are as follows: Temperature 98.6F, HR 84, BP 132/74, RR 16
- Last calculated BMI 33.1

Reviewed Patient Continence Education:
Completion of bladder/incontinence diary.
Pelvic floor muscle exercise instructions (how to perform and how often).
Urge suppression exercises (how to perform).
Utilization of incontinence containment devices.
Daily diet and fluid intake urinary recommendations.
Daily exercise/physical activity goals for weight loss.

Recommendations:
Begin PFME and urge suppression exercises as directed.
Utilize incontinence containment devices as needed.
Initiate lifestyle and diet modifications as directed to decrease incontinence symptoms.
Schedule follow-up appointment with WOC outpatient team as instructed, after diary and testing completed.

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?

I chose this virtual clinical topic as I did not have an opportunity during in-person clinic time to really discuss PFMT with patients. In some situations, it was brought up as an option but never fully discussed or taught. I wanted to review the therapy more in depth and review important teaching points to touch on with patients. I feel I was able to meet this

goal as I covered pelvic floor exercises in my education points in depth, I reviewed how to teach patients these exercises, and what to expect during therapy.

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		