Cleveland Clinic

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Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Patricia Weimer Day/Date: 10/21/2024

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*: 68-year-old Male *PMH*: 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. *CC*: "New onset urinary incontinence" *Meds*: Lisinopril 20mg PO daily, Metformin 500mg BID with meals, Percocet 5/325mg PO prn for pain *Social hx*: ½ ppd. smoker, Recreational "4 or 5 beers to fall asleep" *Labs:* None available

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?

- Cognitive status: Is he cognitively able to record his incontinence in a diary for 48 to 72 hours? Documentation states he is alert and oriented but this does not necessarily mean he is able to record data needed to assist identifying interventions that could reduce or treat his incontinence.

- Social support: If he cannot see and record measurement and time of intake and output, is there someone at his current residence who can assist him?

- Visual status: Has stated legally blind status, what exactly can he see? Can he see enough to find the bathroom? A Urinal? Is he able to record information in an incontinence diary? (Occupational Therapy Consult)

- Additional information regarding current living accommodations: For example, how far is the nearest bathroom from where he sleeps or spends the majority of his day when awake? Are there additional occupants in the home with only one bathroom, causing the bathroom to be unavailable when needed? Does he have and/or use a urinal? (Occupational Therapy Consult)

- How frequently does he take the Percocet for pain? (Record on Incontinence Diary) Narcotics contribute to sedation and relax the bladder, causing it to retain urine. Frequency and timing of PRN narcotic medication doses are needed to plan incontinent interventions.

- When does he take his Lisinopril? How long has he been taking this medication? Lisinopril causes drowsiness.

- Explore his report of daily alcohol consumption. Is he interested in addressing this? Is he open to accepting the connection between alcohol consumption and his incontinence? Education needed: Alcohol is a bladder irritant and it suppresses the antidiuretic hormone so his body produces more urine when he drinks. Normal alcohol consumption for a male is 2 drinks per 24 hours, his reported intake is over double that.

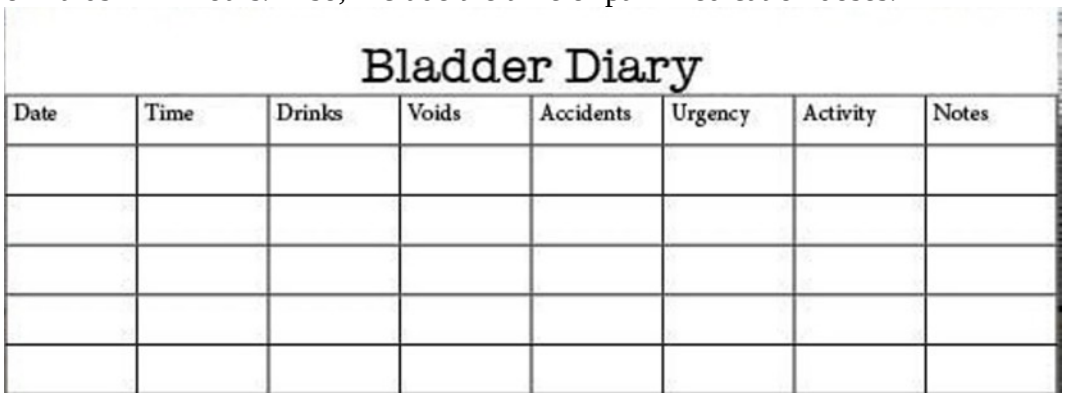
-Explore willingness to stop smoking. Explain smokers are at an increased risk for incontinence due to chronic cough, which puts pressure on the pelvic muscles, causing them to weaken. This increases the chance

of stress incontinence.

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)

Return to clinic in 4 days to evaluate 3-day incontinence diary. Incontinence diary to include input and output of fluids X 72 hours. Also, Include the time of pain medication doses.



Bladder Diary

Date	Time	Drinks	Voids	Accidents	Urgency	Activity	Notes

Provide patient with a male urinal today at the end of his clinic visit. Explain measurement markings on urinal for use with incontinence diary.

Occupational therapy referral to evaluate current living environment and assess upper body strength related to mobility via crutches.

Physical therapy referral to evaluate mobility related to lower body strength, use of crutches, and limitations related to obesity and osteoarthritis.

Dietician referral for weight loss and diabetic nutritional counseling.

Social Services or Psychologist referral to evaluate alcohol misuse disorder, smoking cessation, and available support services. Explore inpatient substance abuse program need and willingness to stop drinking.

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 assessed in clinic today for new-onset urinary incontinence. Medical history of diabetes

type II, obesity, hypertension, and osteoarthritis. Ambulates on crutches due to surgical repair of compound left tibial fracture 3 weeks prior. Legally blind. Self-reports 4 to 5 alcoholic units per evening. Currently resides in the home of a friend due to inability to climb stairs to his home. Social support related to care is unknown.
Introduced and explained bladder diary (Example attached in Plan of Care). Instructed patient to record pain medication use on the same form, keeping documentation as simple as possible. Instructed to complete for three days and return to clinic on the fourth day.
Discussed the multiple factors that may contribute to his incontinence (mobility (osteoarthritis, obesity, and crutches), blindness, pain medication, blood pressure medication, alcohol use, smoking, and environment of care). Referrals to Home Health Skilled Nursing, PT, OT, Dietician, and Social Services or Psychologist. Patient compliance with referrals and incontinence diary will influence future treatment planning.

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?

My goal is to complete needed continence requirements and increase my knowledge regarding continence. This case study is related to functional incontinence. I chose this scenario because it appears simple, but quickly reveals complexity with multiple contributing factors that influence incontinence. Given these factors, this may be more than functional incontinence. Once his mobility issues are resolved by his fracture healing, he should be able to reverse his incontinence issues however he has multiple additional factors that contribute and may require long-term interventions.
I am able to meet my goal with this scenario by addressing the role of mobility, alcohol use, smoking, pain and blood pressure medications, visual limitations, and psychological factors that relate to incontinence.

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		