Cleveland Clinic

R. B. Turnbull Jr. MD WOC Nursing Education Program

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Gabriel Macharia Day/Date: 21st June, 2025

Setting: Virtual

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

1. Identify what would you have done differently regarding assessment data collected, treatment recommendations, and education?

The assessment offered a strong foundation for identifying the patient's continence difficulties, but further data might help clinical decision-making. Incorporating a bladder diary would provide for a more complete analysis of the frequency, volume, and timing of incontinence episodes. This might assist distinguish between functional incontinence and other forms, such as urge or overflow incontinence. A post-void residual bladder scan could also help determine whether incomplete bladder emptying is causing his symptoms. A urinalysis and urine culture could help rule out a urinary tract infection, which is a common cause of new-onset incontinence, especially in older adults.

The patient's fall risk and limited mobility indicate the necessity for a home safety review. Given that he is in a transitory housing situation and uses crutches, he may have limited access to safe and timely toileting. His use of alcohol to promote sleep raises further concerns, as alcohol has diuretic characteristics and may impair balance and judgment at night. Education should have emphasized the significance of limiting alcohol consumption, using assistive devices safely, and employing measures such as planned voiding. To avoid moisture-related skin damage, it is also vital to teach perineal skin care and the use of barrier lotions. These additional components would offer a more thorough and preventative strategy to controlling the patient's incontinence.

2. WOC Plan of Care (include specific products used)

- Initiate bladder diary for 3 consecutive days to track frequency, volume, and incontinence episodes.
- Recommend scheduled voiding every 2-3 hours during daytime and immediately before bedtime.
- Encourage use of bedside commode or urinal at night to reduce falls and facilitate toileting.
- Apply moisture barrier cream (e.g., Cavilon™ Durable Barrier Cream) to perineal area twice daily and after episodes of incontinence.
- Provide absorbent male incontinence briefs (e.g., TENA® Men’s Protective Underwear) for daytime use.
- Evaluate skin integrity daily for signs of MASD or pressure injury.
- Educate on reducing or eliminating alcohol intake, especially before bed, due to its bladder irritant and diuretic effects.
- Refer to Occupational Therapy for evaluation of home environment and adaptive equipment for toileting.
- Reinforce safe crutch usage and instruct on non-weight-bearing techniques, ensuring the patient understands fall prevention strategies.
- Monitor blood pressure and glucose control as these co-morbidities may contribute to continence issues.
- Follow-up appointment in 1–2 weeks or sooner if symptoms worsen.

3. Chart note:

Initial consult for evaluation and management of new-onset urinary incontinence in a 68-year-old male with limited mobility following left tibial fracture surgery.

The patient suffered a complex fracture of the left tibia in a car accident three weeks ago and had surgery. He is now non-weight considering the injured limb and requires crutches for movement. Due to mobility issues and the presence of stairs in his home, he is temporarily living with a friend in a flat-level apartment. The patient reports having trouble reaching the restroom on time, especially at night, which results in episodes of incontinence. He denies burning, urgency, or suprapubic discomfort, but he is frustrated with his current situation and cites a recent fall.

Upon examination, the patient seemed well-nourished, correctly dressed, and in no acute discomfort. He was conscious and focused on the person, place, time, and circumstance. The breathing was regular and unlabored. The heart sounds were normal. The abdomen was soft and non-tender, with lively bowel sounds in all four quadrants. The musculoskeletal assessment indicated a typical active range of motion, with arthritis in both hands. During the appointment, the patient successfully emptied into a urinal with ease. There were no rashes or sores on the skin, and no evidence of perineal irritation or moisture damage were found. His BMI was determined to be 29.5, placing him in the overweight category.

A three-day bladder diary, as well as a scheduled voiding routine, were advised to help with continence. A bedside commode was proposed to increase toileting access at night and lower the danger of falling. To protect the perineal area, it was recommended to utilize Cavilon™ moisture barrier cream and TENA® Men's Protective Underwear, which are absorbent for everyday use. The patient was taught how to use crutches safely, how to care for his skin, and how alcohol affects his bladder and balance. A referral to occupational therapy was issued for home safety and toileting improvements. A follow-up appointment is scheduled for one to two weeks, or sooner if the illness worsens.

4. What was your goal for choosing this case?

The fundamental reason for picking this case was to improve clinical judgment and planning in the care of functional incontinence, particularly in older persons recuperating from surgery. This example presented a chance to think about how mobility disabilities, environmental impediments, co-morbidities, and behavioral patterns like alcohol consumption combine to influence continence and safety. The issue necessitated a comprehensive and patient-centered strategy that included continence care, fall prevention, skin protection, and patient education. The goal was met, as it enabled the integration of WOC nursing concepts with practical and evidence-based practices that promote patient independence and dignity in the home care setting.

Reviewed by: _____ Date: _____

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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	✓	

• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	
• Braden subscales addressed (if pertinent)	✓	
• 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	✓	