Cleveland Clinic

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Daily Journal Entry with Plan of Care & Chart Note

Student Name: Elizabeth Lyons Day/Date: 10/14/25

Number of Clinical Hours Today: 8

Care Setting: Hospital ____ Ambulatory Care __X__ Home Care ____ Other ___

Preceptor: Caryn Ascherman

Clinical Focus: Wound ___ Ostomy ____ Continence ___X_

This assignment should be WOC focused and approached as both patient documentation and critical thinking development. Complete each section of the document. Once you have completed the form, save the document by clinical date and preceptor. Submit to your Practicum Course dropbox for instructor review & feedback. Journals should be submitted to your dropbox no later than **48 hours** following the clinical experience day. See samples in course Resource area to assist you with this assignment.

Reflection: Describe your patient encounters & types of patients seen.

Most of the patients today were male with hx of BPH.
One female patient, 79 years old, was being evaluated for recurrent UTIs. There was difficulty with the machinery which required stopping the test altogether and restarting it. Then, her desire to void was triggered with less than 200mL instilled, then unable to void with sensors indwelling when testing was completed, required removal of indwelling sensors and going to bathroom on regular toilet to void.

WOC nurses function as consultants and develop plans of care (POC) for other care givers as a guide to providing care in the WOC nurse's absence. For this part, select one patient who is an example of the identified specialty hours for this clinical day. Write a chart note giving careful consideration to 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 were used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

Chart note:

69 yo male
PMH: BPH s/p Rezum procedure 2022, prostate nodule, ADHD, seasonal allergies. Non-smoker.
CC: LUTS
LUTS had been managed with Flomax to help urinary flow with decreased efficacy and switched to Tadalafil.
Reports times of urinary urgency; has not made it to the toilet in time 2x in the past year.
Pt denies s/s of UTI
Current medications: Tadalafil, Adderall XR, Ubrogepant, cetirizine, escitalopram, lidocaine patch, acetaminophen
Labs: PSA 1.5; UA WNL
Today pt is scheduled for urodynamic study for bladder assessment and r/o overactive bladder, cystoscopy to assess whether prostate has regrown, and MRI to evaluate prostate nodule.
Pt was seen and initially voided 200mL during uroflowmetry pretest, flow time was 34 seconds and PVR 125mL was measured after catheterizing using lubricated 14Fr catheter. Lidocaine gel was injected into urethra prior to catheterization. Lubricated sensors were then inserted into bladder and rectum. Uroflow showed compressed, elevated line that tapered at the end, indicating obstructed flow. Average flow rate for age is 9ml/s, pt;s 5.9m;/s. Further evaluation already scheduled to help determine cause. Cystometrogram with EMG was then performed. No first sensation felt by patient, per his report. Strong desire to void was reported by patient at 274mL of NS instillation. Max capacity: 360mL. Maximum filling detrusor pressure 6cm. No detrusor overactivity was associated with urge or leakage. Pt exhibited very slow flow and high pressure detrusor contraction which can indicate bladder

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outlet osbstruction. (Peak pressure 69.2cmH20, mean pressure 75.5cmH20; normal 25-50).
Pressure-flow voiding study performed and pt voided with catheters in place, 181mL, but required standing to void. max voiding detrusor pressure 69cm water; pressure detrusor at max flow: 62cm water; maximum flow rate 9ml/sec and average flow rate 3ml/sec. Once catheter sensors removed, pt voided 150ml more in the bathroom.
Pt tolerated testing well, denied complaints.
Reviewed that some soreness after testing may be felt and a small amount of blood in the urine can also occur. Instructed to drink 16 ounces of water every hour for two hours to help ease this. Instructed to call provider should any s/s infection or unrelieved pain occur.

Using the information from the chart note, 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.

WOC Plan of Care (include specific products used)

Complete MRI and cystoscopy scheduled today.
Drink 16 ounces of water every hour for two hours after procedure, if able.
Follow directions and medications prescribed following testing and meeting with MD.
To decrease nocturia, limit fluids four hours prior to bedtime.
Continue getting 30 minutes of physical activity daily.
Decrease caffeine to one cup of coffee a day.
Keep bladder diary for 3 days prior to next visit.

Describe your thoughts related to the care provided. What would you have done differently?

I thought today and urodynamic testing was fascinating! I really enjoyed learning about something that I have never been exposed to in my career. As I was completing this journal, I wished I could have investigated more in depth the patient's symptoms (and exactly what were the LUTS other than urgency at times).

You should have a learning goal for each clinical day. What was your goal for the day? Was it met? Why or why not?

Goals

What was your goal for the day?
To better understand urodynamic testing and when to use specific tests.

What is/are your learning goal(s) for tomorrow? **(Share learning goal with preceptor)**
Understand and perform obtaining urine C & S from ileal conduit
Or Manage a high output ECF

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 ~~pertinent~~ labs		
*Identifies specific products utilized/recommended for use		

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*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		

Reviewed by: _____ Date: _____

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