Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Alice Pownall-Gray Day/Date: 10 20/2025

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?

I would have liked to have had base line labs to see what his glucose levels are. Especially since he may have an ETOH abuse problem. Also, with his age maybe a PSA test, he may have new onset retention from an enlarged prostrate even though he is urinating normally into the urinal, could have residual and not fully emptying his bladder.

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)

1.Use of commode or urinal
2. Wear depends in case of leaks
3. Use of skin barrier to protect skin from urine
4. Change position every two hours to prevent skin breakdown

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:

Pt seen for WOC assessment for new onset urinary incontinent management.
Full medical hx and general assessment completed.
Discussed medications with patient. Especially consequences side effects and safety concerns of mixing pain medications with ETOH. Besides being a fall risk, he may not have the best control of his bladder when he mixes the two.
Recommendations:

1. Use of a commode while he is recovering, so he does not have to walk so far, 24 hr supervision.
2. Wear men's absorbent undergarments to prevent accidents while recovering or until safe to ambulate independently. Use of skin barrier ointment to protect skin and educate on position changes and pressure reduction.
3. Occupational and Physical therapy evaluation for home safety and bathroom transfer safety and evaluation and ordering of home DME equipment needs.
4.Transition weaning from the Percocet to another non opiate pain medication and decrease his ETOH use. 5.
5. Follow with his primary care for labs to check for urinary retention pcs and glucose lab work ups and referral for ETOH abuse counselling.

Follow up visit- remain available if requested.

1.

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 was to obtain more exposure to continence scenarios I may come across in my practice, and develop a logical and profession plan of action

Reviewed by: _____ Date: _____

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CRITICAL ELEMENTS	Completed	Missing
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
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	✓	
• 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:		
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	