Cleveland Clinic

R.B. Turnbull Jr. M.D. WOC Nursing Education Program

Virtual Journal Entry with Plan of Care & Chart Note

Student Name:_____ Day/Date:_____

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:* 81 y/o female *PMH*: G2P2 with two vaginal births, post-menopause, constipation, non-insulin dependent type 2 diabetes mellitus, anxiety, depression, and hypertension. Breast cancer s/p left mastectomy, urinary incontinence: OAB *CC*: Nocturia and incontinence leakage without urge for 20 years but recently has gotten worse. Patient voids in the toilet about twice daily. Leaks into a pad and changes it about 8 times daily. Underwent 100 u Botox injections 2 times in past year and then 2 months ago of 200u. Reports 0% improvement from first injection and 5-10% from second injection. *Social hx*: Never smoked. Widowed, not sexually active. Current medications: Letrozole 2.5mg tab x1 daily, Motoprolol succinate ER 50mg tab x1 daily, Losartan 50mg tab x1 daily, Rosuvastatin 40mg tab x1 daily, Metformin

Assessment/encounter:
Presents to clinic for urodynamic testing and urinary incontinence teaching.
Denies straining when voiding.
Feels she is able to empty her bladder completely.
Has had 2-3 UTI's within the past 12 months.
Fluid intake consists of 2-3 cups daily and 2 cups of caffeine daily.

Skin breakdown assessment:
Location: None
Skin breakdown type:
Extent of tissue loss:
Size & shape:
Wound bed tissue:
Exudate amount, odor, consistency:
Undermining/tunneling:
Edges:
Periwound skin:
Pain: Denies
Rectal vault assessment: Deferred

Urodynamic studies completed: Voided volume- 153mL, PVR- 200mL, never felt first sensation, strong desire- 485mL, max capacity- 501mL Detrusor over activity associated with urge. Patient voided with catheter in place of 340mL voluntarily plus 200mL more in toilet post-test. No leaks with stress. Interpretation: Detrusor over activity, Detrusor underactivity.

Education: Lifestyle modifications:
- Avoid bladder irritants
- Increase total fluid intake
- Prevent constipation
- Continue Botox injections

Suggested consults: identify in note

Photo: None

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 had the patient keep a bladder diary prior to the visit and instructed her to bring to this visit.

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)

Increase fluids to 10-12 8 oz glasses per day with goal of 2L intake
Decrease caffeine intake to 1 cup per day
Begin scheduled toileting; try to void every 3 hours
Keep a daily voiding/bladder diary. Bring to next appointment
Prevent constipation; increase fluids, increase fiber intake, consider Fibricon or Benefiber
Maintain good glycemic control:
- Adherence to diabetic diet
- Take medications as ordered
- Treat blood sugars as directed

Perform PFME
Continue Botox treatments
Follow-up with urologist
Return to clinic in two weeks

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:

81 year old female with OAB. Presents to clinic today for urodynamic testing and urinary incontinence teaching. Reports nocturia and incontinence leakage without urge for 20 years but recently got worse. Fluid intake consists of 2-3 cups daily plus 2 cups of caffeine. Urodynamic studies completed: Voided volume- 153mL, PVR- 200mL, never felt first sensation, strong desire- 485mL, max capacity- 501mL Detrusor over activity associated with urge. Patient voided with catheter in place of 340mL voluntarily plus 200mL more in toilet post-test. No leaks with stress. Interpretation: Detrusor over activity, Detrusor underactivity. Instructed on lifestyle changes of avoiding bladder irritants, decreasing caffeine intake, increasing fluid intake, and voiding every 3 hours. Instructed on bladder diary and encouraged to start and bring to next appointment. Verbalized understanding of education with plan to begin bladder diary. Acknowledged need to follow-up with urologist and to return to clinic in two weeks.

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 wanted to learn more about OAB, urodynamics and Botox injections

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		
• 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		