

Virtual Journal Entry with Plan of Care & Chart NoteStudent Name: Brittany Sluiter Day/Date: Weds/January 7, 2026Setting: 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	<p><u>Age/sex:</u> 68-year-old Male</p> <p><u>PMH:</u> 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.</p> <p><u>CC:</u> "New onset urinary incontinence"</p> <p><u>Meds:</u> Lisinopril 20mg PO daily, Metformin 500mg BID with meals, Percocet 5/325mg PO prn for pain</p> <p><u>Social hx:</u> ½ ppd. smoker, Recreational "4 or 5 beers to fall asleep"</p> <p><u>Labs:</u> None available</p>
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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?

Based on critical evaluation of the encounter data, I would have gathered additional focused continence assessment information, including a more detailed voiding history (frequency, volume, nocturia pattern) and fluid intake timing, particularly related to evening alcohol consumption. I would also have assessed environmental and functional barriers in greater depth, including bathroom accessibility, adaptive equipment needs, and safety concerns related to nighttime toileting. Earlier education regarding behavioral modifications, fall prevention strategies, and bladder retraining may have helped mitigate the patient's frustration and recent fall.

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)

- Initiate scheduled toileting every 2-3 hours while awake
- Encourage use of a bedside urinal or commode to reduce fall risk, especially at night
- Recommend nighttime urinal placement within reach to accommodate limited mobility
- Educate the patient to reduce evening fluid intake, particularly alcohol consumption
- Encourage gradual reduction of alcohol intake used as a sleep aid
- Reinforce safe ambulation techniques using crutches; recommend physical therapy consult for mobility safety, proper crutch use/height/size
- Recommend occupational therapy consultation for home safety evaluation and adaptive equipment needs
- Monitor blood pressure and glycemic control as comorbidities may contribute to continence issues
- Reinforce smoking cessation education
- Recommend follow-up with PCP or urology if urinary incontinence persists
- Provide education on skin care to prevent moisture-associated skin damage due to incontinence

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:

Initial visit for evaluation and management of new onset urinary incontinence.

68 year-old male with past medical history significant for legal blindness, OA, obesity, hypertension, and controlled type II DM. Patient sustained a compound tibial fracture of the left leg requiring surgical repair following an MVA three weeks prior to this visit. Patient reports new onset urinary incontinence since discharge from surgery.

Patient is currently NWB on the left leg and ambulates using crutches provided by a friend. He reports difficulty reaching the bathroom in time, particularly at night, due to mobility limitations and reliance on crutches. Patient currently resides with a friend in a flat residence without stairs but reports frustration with incontinence issues and a recent fall.

Vital signs stable. Patient awake, alert, and attentive, GCS of 15. Physical assessment revealed a well-nourished male in no acute distress. Skin intact with normal color, texture, and turgor. No rashes or lesions noted. Musculoskeletal exam notable for limited mobility related to left leg fracture and a arthritic changed to bilateral hands. Abdomen soft, non-tender with active bowel sounds. Genitourinary assessment revealed ability to void normal into a urinal during the visit.

Medications include lisinopril 20 mg PO daily, metformin 500 mg PO twice daily with meals, and Percocet 5/325 mg PO as needed for pain. Social history is notable for smoking half a pack per day and alcohol intake of four to five beers nightly to aid sleep. No laboratory data is available on this visit.

Education provided regarding behavioral strategies to manage urinary incontinence, fall prevention, and safe toileting practices. Patient verbalized understanding of recommendations.

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 in choosing this case was to further develop my clinical reasoning related to functional urinary incontinence, particularly in the context of acute injury, mobility limitations, environmental barriers, and fall risk. This case allowed me to apply WOC consultant-level thinking focused on functional assessment, behavioral interventions, and interdisciplinary collaboration.

Reviewed by: _____ Date: _____

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CRITICAL ELEMENTS	Completed	Missing
Thoughts Related to Visit:		
<ul style="list-style-type: none"> Critical thinking utilized to reflect on patient encounter 	✓	



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• 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	✓	