Cleveland Clinic

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

**Daily Journal Entry with Chart Note & Plan of Care**

Student Name: _Crystal Wilson_____ Day/Date: _Mon. 1/12/26_____

Number of Clinical Hours Today: __8__ Number of patients seen__**4**__

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

Preceptor: _Urodynamics (Jessica)/ WOCN (Jeanine)_____

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, and any additional activities.**

Today's clinical experience focused on continence care, with the morning spent in the urodynamics lab and the afternoon transitioning to inpatient WOC nursing. This allowed for exposure to both diagnostic evaluation of lower urinary tract dysfunction and acute inpatient ostomy management. The first patient encounter occurred in the urodynamics lab and is the patient selected for my chart note. This patient presented with complex lower urinary tract symptoms following prostate cancer treatment and aquablation. I observed and participated in advanced diagnostic testing including uroflowmetry, cystometrogram with EMG, and pressure-flow voiding studies. This encounter enhanced my understanding of bladder sensation, compliance, detrusor pressures, and the clinical significance of pressure-flow relationships in obstructive voiding. The second urodynamics patient was an older female presenting with urinary incontinence, primarily urge incontinence. She tolerated the testing well. This encounter reinforced the importance of correlating patient-reported symptoms with urodynamic findings to guide appropriate continence management strategies. Following urodynamics, I joined inpatient WOC nursing and saw two additional patients. The first inpatient patient was post-operative day #3 with an end ileostomy and a history of Crohn's disease, who was experiencing abdominal distention, nausea, and lack of ostomy output. WOC nursing was consulted for stoma intubation. The stoma was successfully intubated using a 16 French catheter, irrigated with 60 mL, yielding approximately 125 mL of output. The catheter was left in place and a pouch change was completed. The final patient had a history of rectal cancer with familial adenomatous polyposis (FAP) and bleeding from a complex fistula involving the uterus, vagina, and rectal stump. The patient has an end jejunostomy and was seen for a leaking pouch. A pouch change was performed successfully with resolution of leakage. This clinical day strengthened my continence assessment skills through exposure to urodynamic testing and reinforced complex ostomy management skills in the inpatient setting. It highlighted the consultant role of the WOC

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nurse and the importance of individualized plans of care.

## Types of Patients Seen

- Patients undergoing urodynamic testing
- Patients with urge urinary incontinence
- Patients with lower urinary tract obstruction
- Post-operative patients with end ileostomy
- Patients with Crohn's disease
- Oncology patients with rectal and prostate cancer
- Patients with complex fistulas and end jejunostomy

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. 1. select one patient who is an example of the identified specialty hours for this clinical day. 2. Write a chart note beginning with a brief, focused history and history of present illness, including why you are seeing the patient. 3. describe the visit including any physical assessment, interactions, interventions, and evaluations. 4. Complete a Braden Scale assessment if this was an inpatient encounter. 5. Identify any specific products used or recommended for use. Remember, this note reflects all that *was **done*** during the visit.

The plan of care reflects your direction/orders to another care provider *after* the encounter to be performed in your absence.

**Chart note:**

Patient: 66-year-old male

Reason for Visit: Evaluation of persistent lower urinary tract symptoms with urodynamic testing

## History / HPI

Patient with history of prostate cancer diagnosed in 2013, status post aquablation approximately 9–10 months ago. Despite intervention, patient reports persistent prostatic obstruction with worsening urinary symptoms. Patient presents today for comprehensive urodynamic evaluation including uroflowmetry, cystometrogram (CMG), EMG, and pressure-flow voiding study.

## Assessment / Encounter

- Patient unable to provide pre-test uroflow
- Unable to pass straight catheter

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- Testing catheter utilized; bladder drained for 75 mL prior to testing
- Bladder and rectal catheters placed successfully
- CMG performed with EMG monitoring

CMG Findings:

- First sensation at 115 mL
- Strong desire at 393 mL
- Maximum capacity at 395 mL
- Maximum filling detrusor pressure: 17 cm $H_2O$
- No detrusor overactivity
- No urinary leakage observed

Pressure-Flow Study:

- Patient voided 342 mL with catheters in place
- Maximum voiding detrusor pressure: 58 cm $H_2O$
- Maximum flow pressure: 52 cm $H_2O$
- Gradual rise in vesical and detrusor pressures during filling
- Strong desire to void reported; permission given
- Voluntary void of 223 mL
- Vesical pressure catheter removed to aid voiding
- Additional voluntary void of 119 mL
- Additional 300 mL voided in bathroom post-testing

## Patient Response

- Tolerated procedure well
- Pain score: 0/10
- Reports discomfort only at maximum bladder capacity

## Products / Equipment Used

- Urodynamic testing catheters
- EMG monitoring equipment

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)**

1. Continue urology-directed evaluation and management based on urodynamic findings.

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2. Monitor urinary symptoms including frequency, urgency, hesitancy, and sensation of incomplete emptying.
3. Educate patient on recognizing signs of urinary retention, infection, or worsening obstruction and when to seek care.
4. Encourage adequate hydration unless otherwise contraindicated by provider.
5. Follow up with urology for interpretation of pressure-flow study and treatment planning.

**Describe your thoughts related to the care provided. What would <u>you</u> have done differently**

This encounter reinforced the complexity of evaluating lower urinary tract dysfunction and the importance of urodynamic testing in guiding treatment decisions. I felt comfortable observing and assisting with the testing process and interpreting key findings.
What I would have done differently: I would like to further strengthen my ability to independently interpret pressure-flow relationships and correlate them with specific treatment options. Continued exposure to urodynamics would help solidify these skills instead of just 4 hours of being there.

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?**
My goal was to gain a better understanding of urodynamic testing and how it is used to evaluate continence and voiding dysfunction. This goal was met through direct observation, participation, and discussion of test results with the care team.

**What is/are your learning goal(s) for tomorrow? (Share learning goal with preceptor)**

My goal for tomorrow is to improve my hands-on ostomy care skills by assisting with pouch changes, assessing stoma characteristics and peristomal skin integrity, and applying appropriate pouching systems. I will also aim to enhance my patient education skills by providing individualized teaching on ostomy management, skin protection, and troubleshooting common issues.

**For instructor use only. Do <u>not</u> remove or edit:**

| 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 | ✔ | |

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| | | |
|---|---|---|
| ● 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 | ✔ | |

Reviewed by: _____ Date: _____

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