Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Jessica Whelen Day/Date: 7/21/2025

Setting: Hospital ☐ Ambulatory Care ý 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:* 37-year-old female *PMH:* Crohn's, diverticulitis, bowel resection, ileostomy placement, hypertension, rheumatoid arthritis, and depression. Patient with many reported allergies to foods and environment. Patient was experiencing symptom exacerbation related to her diverticulitis diagnosis to which she went to the ER 8 weeks ago. Work up discovered severe adhesion and patient had a RUQ loop ileostomy placed with a bowel resection. *CC:* Pain under ostomy appliance. *Meds:* Methotrexate, Prednisone, Sertraline, Hydralazine, Vicodin PRN, Tylenol PRN, Over the counter Probiotic *Social hx:* Denies smoking, ETOH or illicit drug use *Labs:* Labs drawn at last outpatient appointment and unremarkable. Patient had called ostomy clinic due to a new wound in her peristomal plane and was advised by the tech to come into the ostomy clinic.

Assessment/encounter:
Ostomy nurse visit today in the outpatient clinic.
LOC: Patient awake and alert
Interview with patient

- Independent in ostomy care
- Had a pinpoint area that "erupted" and has been "extremely" painful with lots of drainage under her pouch
- No further issues or other changes since her hospital discharge
- No missed ostomy clinic appointments
- Wears Convatec Sur-fit Natura 1 ¾" flat flange with drainable pouch
- Empties pouch 4-5 times per day.
- Appliance changes every 3-4 days
- Current 1-2 day wear time due to wound drainage disrupting seal

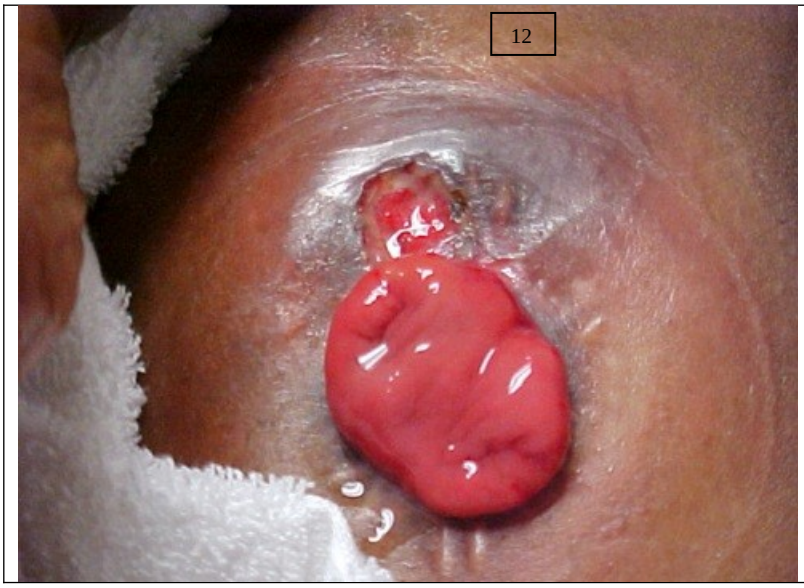
Stoma: Loop ileostomy, pink, moist,
Stoma size: 1.3x 1.0"
Shape: round
Peri-stomal skin: full thickness wound at 12 o'clock aspect noted with heavy serous drainage and violaceous edges.
Abdominal plane: semi-soft, flat, painful on palpation.
Education

- Develop education below

The patient is exasperated with the pain associated with her pouch change and feel she is in a "catch 22".
Patient will be returning home after this visit.

What specific interventions would you choose as the Ostomy provider? Make sure to include below, considering both short and long term plans for this patient.

Photo



Using critical evaluation of the provided encounter data, identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

1. Identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

I would have asked if there is a history of previous skin infections or recurrent boils, history of recent injury, insect bites
Is there underlying skin conditions that have not been previously mentioned. Labs that could be obtained wound culture to rule out if an organism is the causative factor, CBC, check the AIC to see how well DM is controlled. Patient may need a referral to a dermatologist for definitive diagnosis and further treatment. Identify any barriers to healing nutritional status. Pyoderma is what my brain is thinking given the fact that she has an autoimmune disorder. Treatment would be tricky to manage where the lesion location relative to the stoma. I would recommend local treatment first. I would start with local wound care. Treatment I would start with a hydrofiber, like Aquacel AG and cover with Hollihesive by cutting a keyhole to fit around stoma and cover the wound completely for a pouching surface. I would have the patient follow in 1 week or sooner for assessment. If treatment needs to be escalated, I consider topical treatment with Tacrolimus and consider the need for systemic treatment, work in collaboration with primary care provideder.

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 ostomy pouch change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

Wound care instructions:
Change Ostomy appliance every 3 days and as needed. Remove old ostomy wafer use a warm washcloth. Cleanse skin surrounding stoma, at site of ulceration clean with gauze moisten with normal saline. Cut a patch of Aquacel Ag to fit over ulceration. Cut a keyhole in to piece of Hollihesvie to fit around stoma and over top of ulceration. This will create a pouchable surface over ulceration. Apply barrier wafer, attach pouch. May use Coloplast barrier strip to help secure and provide support to skin barrier.

Cleveland Clinic

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

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:

Patient is a 37F with Crohn's, diverticulitis, s/p RUQ loop ileostomy 8 weeks ago, presents with severe pain under ostomy appliance. Reports pinpoint area that "erupted" with heavy serous drainage; wear time reduced to 1–2 days. Empties pouch 4–5×/day. Frustrated with pain during pouch changes, describes feeling "stuck in a catch-22." Independent in ostomy care. No new systemic symptoms or missed follow-ups.
Patient is currently using Convatec Sur-fit Natura 1 ¾" flat flange with drainable pouch.

Stoma Assessment:
Stoma: Loop ileostomy, pink, moist, round, 1.3 × 1.0 in.
Stoma Function: stable
Peristomal skin: Full-thickness wound at 12 o'clock with violaceous edges, heavy serous drainage; surrounding skin intact.
Abdominal: Semi-soft, flat, tender to palpation.

Intervention:
Removed existing appliance and gently cleansed peristomal skin with pH-balanced cleanser. Assessed wound drainage and skin integrity; applied Aquacel Ag dressing to ulceration to manage effluent and offload wound, utilized holliheasve sheet fashioned as a barrier ring to create a pouchable surface to place new Convatec Sur-fit Natura barrier.

Provided pain management recommendations and strategies to reduce pouch change discomfort.
Reviewed appliance management strategies, how to protect wound, how frequent the pouch change should be. Advised patient to seek medical attention if she should experience sign and symptom of infection including increasing redness, warmth, purulent drainage, fever, or foul odor.

Plan is to follow up with ostomy clinic in one week or sooner if there is increase drainage.

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 is to learn more about treatment and management of pyoderma in the setting of ostomy. How to recognize and the steps I need to take to assist the patient, in both pouch management, treatment, and referrals for potential diagnosis.

Reviewed by: _____ Date: _____

For instructor use only. Do not remove or edit

Cleveland Clinic

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

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
• Identifies why the patient is being seen	ü	
• Describes the encounter including assessment, interactions, any actions, education provided and responses	ü	
• Completes Braden Scale for inpatient encounter	ü	
• Includes pertinent PMH, HPI, current medications and labs	ü	
• Identifies specific products utilized/recommended for use	ü	
• Identifies overall recommendations/plan	ü	
Plan of Care Development:		
• POC is focused and holistic	ü	
• WOC nursing concerns and medical conditions, co-morbidities are incorporated	ü	
• Braden subscales addressed (if pertinent)	ü	
• Statements direct care of the patient in the absence of the WOC nurse	ü	
• Directives are written as nursing orders	ü	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	ü	
• Identifies alternatives/what would have done differently	ü	
Learning goal identified	ü	