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: 7/26/2025

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:* 56-year-old female *PMH* Ulcerating Crohn's, constipation, C Diff, morbid obesity, depression, anxiety, poorly controlled diabetes type 2, hypertension and hyperlipidemia. Previous surgery 2 months ago for LUQ loop ileostomy. Patient has an extensive history of colonic resections and abdominal surgeries. *CC: P*resented in the ED four hours ago with weakness, fatigue, and failure to maintain her ostomy appliance *Social hx: C*hronic ETOH abuse, smokes "socially" and denies illicit drug use. The patient has no ostomy supplies with her and it is noted that she had missed her scheduled follow up appointment with an ostomy nurse. *Labs*: Pending No ostomy output is documented since her ED admission

Assessment/encounter:

Patient noted to be holding a towel in place over stoma upon encounter. Significant other at bedside.

LOC: Patient awake, alert, oriented, tearful.

Interview with patient who states

- had "really increased" output from her ileostomy this week.
- turned down ostomy education from this surgery because she "had a colostomy before"
- is using leftover "Convatec" supplies from her previous surgery. She has not filled her post-op ostomy order.
- has bouts of dizziness resulting in a fall today that prompted her partner to bring her to the ED
- reports 10/10 peristomal pain

Stoma: Moist, red and flush. High function noted with liquid yellow effluent.

Stoma size: 2.0 x 2.0 in

Shape: round, both lumens visualized

Peri-stomal skin: Red, denuded and irritated peristomally, with redness extending to abdominal folds. Painful.

Abdominal plane: highly irregular with scars and many folds when patient changes position.

Education

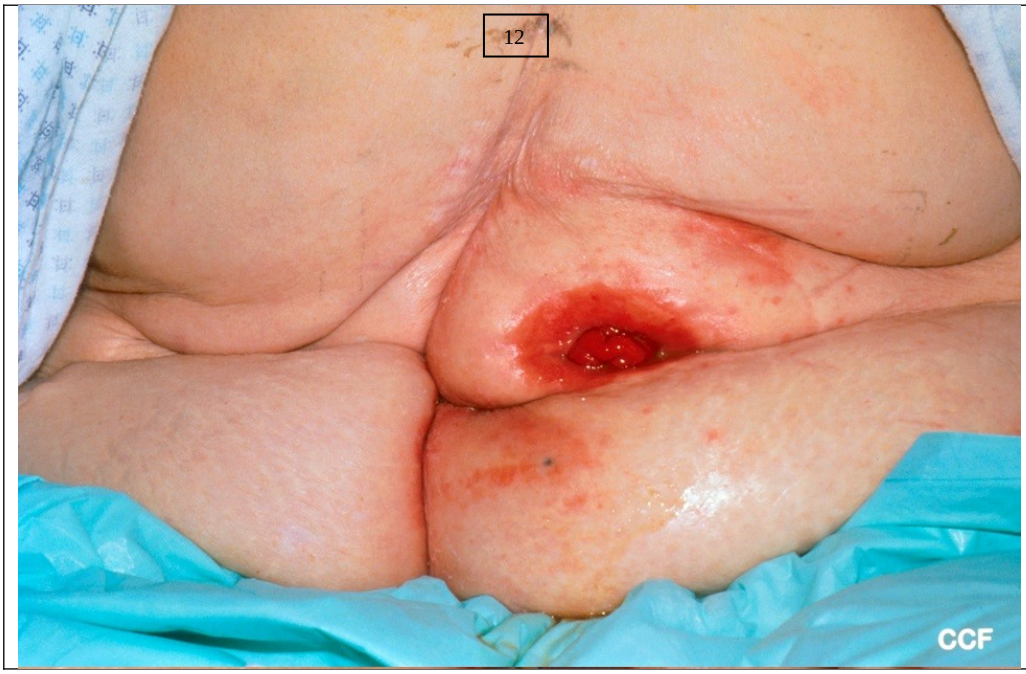
- Poor understanding of patient situation noted by the patient and significant other. Patient has a severe lack of knowledge regarding her situation.
- Patient missed previous educational appointment.
- Resistant to education until her pain and output are controlled.

Treatment

- Tolerated 15 min domboros soak to denuded skin and fitting into a new system
- Patient is to be admitted to the medical surgical floor for observation.

What specific system 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.

A consult for the WOC nurse be the priority at time of arrival for patient evaluation and treatment, this would include Vital signs, pain control and pouching system for the ostomy. It is important to have an accurate assessment of output. Patients' labs should be completed as a priority, as well as starting an IV to start rehydration. Given the high output and the knowledge of the patient symptoms of dizziness, weakness, and fatigue she will require hydration support. Recommend patient be admitted for 24 hour observation to monitor I&O, replace fluid and electrolytes per primary team. Recommend starting patient on antimotility medication, such as Lomotil or loperamide.

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)

Nursing Order: Change ileostomy pouching system every 3 days or as needed for leaking. Use Coloplast SenSura Mio Convex Flip with elastic barrier strips to accommodate irregular abdominal contours. Use a protective barrier ring and Hollihesive sheet to protect skin and enhance seal. Gentle cleanses peristomal skin with warm wash cloth or with pH balance skin cleaner, followed by 15-minute Domeboro soak for denuded skin. Allow skin to dry, using stoma powder, dust peristomal skin ensuring to dust all lose powder off. Next use Cavilon No sting skin prep and dab around peristomal skin. Make a keyhole in Hollihesive sheet and place around stoma. Apply protective barrier ring to wafer to enhance seal. Apply wafer over stoma, secure with elastic barrier strips for securement.
Nursing order: Monitor and record intake and output Q4 hours.
Nursing order: Record Vital Signs Q4 hours
Nursing order: Implement fall precautions per policy.

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:

This is an initial consult for a 56-year-old female for evaluation and management of high-output ileostomy, sever peristomal kin breakdown and appliance failure. Patient with a PMH significant for ulcerating Crohn's disease, multiple abdominal surgeries, morbid obesity, poorly controlled type 2 diabetes, hypertension, hyperlipidemia, chronic C. diff infection, depression, anxiety, and constipation. She presented to the ED four hours ago with severe fatigue, weakness, and inability to maintain her ostomy appliance. Reports a week of markedly increased ileostomy output and severe peristomal pain (10/10). Experienced dizziness and a fall earlier today. She has not been able to keep an ostomy pouch in place and arrived without supplies. Admits to missed follow-up appointments and limited understanding of current ostomy management. Patient lives at home with husband, admits to chromic alcohol use, occasional smoking, and no illicit drug use.

Patient is A&O x 3 appears to be in acute distress, tearful, and fatigued. Patient currently has no appliance in place.
Stoma:
LUQ loop ileostomy stoma appears moist and red, flush with skin. Stoma measures 2'x 2'; both lumens are patient, effluent is yellow and liquid. Stoma is very active.
Peri Stomal skin:
Skin appears severely denuded, erythema extending into the abdominal folds. Painful to touch.
Abdomen:
Soft with multiple scars, irregular contours, and deep fold.
Labs pending, no documented output since arrival to the ED

Intervention:
Gentle peristomal skin cleansing followed by 15-minute Domeboro soak for denuded skin. Patient fitted with Coloplast SenSura Mio Convex Flip, extended-wear cut-to-fit pouching system to accommodate irregular abdominal contours a protective barrier ring and Hollihesvie sheet used around stoma to protect compromised skin and enhance seal.

Plan/Recommendations:
Patient should be admitted to med/surgical floor for observation and management. Pain control per primary team. Monitor patient for dehydration replace fluids/electrolytes per provider orders. Consider anti-motility medication for output that exceeded > 1500 ml in 24h. Consult Nutrition to discuss diet and dietary modification to control high ostomy output; endocrinology for on going glycemic control and Case management supply access. Social work consults for resource/ counseling for ETOH use disorders. WOC nurse with continue to follow patient while inpatient for continued ostomy education.

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?

The learning goal is to assess knowledge appropriate recommendations and interventions when care for a patient with ETOH use. Explore the importance of interdisciplinary care coordination. This case study helps reinforce the importance of addressing barriers to patient education and follow-ups.

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		
• Completes Braden Scale for inpatient encounter	✓	
• 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	✓	