

Virtual Journal Entry with Plan of Care & Chart Note

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 Day/Date: 08/19/2025

 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	<p><u>Age/sex</u>: 56-year-old female</p> <p><u>PMH</u> 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.</p> <p><u>CC</u>: Presented in the ED four hours ago with weakness, fatigue, and failure to maintain her ostomy appliance</p> <p><u>Social hx</u>: Chronic 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.</p> <p><u>Labs</u>: Pending</p> <p>No ostomy output is documented since her ED admission</p>
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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.

As an ostomy nurse, I would like to know were there changes in medication, dietary intake, and fluid intake this past week that could have been contributing to the increased output? I would like to know how this patient normally ambulates. Can she visualize her ostomy? Does she have good finger dexterity? Does she have good eyesight? Can she read and write? All of these could be the contributing factors to not providing an adequate ileostomy care and not filling out the post-op ostomy order. Did she have a stoma marking prior to the ileostomy creation? Does she have any other skin injury/breakdown?

Lab work was pending, but it would also reveal additional information to the treatment team regarding patient's health status. Does she have an infection? How are her electrolytes? How is her kidney and liver function? I also want to know patient's vital signs, whether patient is afebrile. What is her blood glucose level? Also, this patient might need some imaging, such as ultrasound of abdomen to rule out any obstruction. Patient is s/p fall, and we would need to rule out any fractures. It is important to collect strict input and output to monitor patient's hydration status. In terms of stoma itself, I would need to know additional data, such as whether mucocutaneous junction is intact, stoma protrusion, softness of peristomal skin, etc.

From this scenario it seems that this patient has difficulties maintaining regular daily functions and ostomy care. We do not know what medications she is taking, if any. We know that she suffers from depression in addition to other debilitating health conditions (diabetes, morbid obesity hypertension, ulcerative colitis, constipation), and that she consumes alcohol, which is a depressant that contributes to her overall decline in mental state. This patient would benefit greatly from the outpatient alcohol detox and management program in addition to the smoking cessation program. I would like to know, what support does she have besides her significant other? Does patient have transportation, or does the lack of transportation prevent her from getting medical care? Does she have health insurance?

Due to severe pain, this patient needs to have an adequate pain management plan. This patient would greatly benefit from the help of primary care provider, endocrinologist, gastroenterologist, cardiologist, ostomy nurse, nutritionist, social worker, possibly services from a visiting nurse, and a home health aide. This patient would benefit from having a reliable caregiver, and both would need extensive education on how to manage patient's diabetes, hypertension, provide ileostomy care, and how to order supplies. Additionally, this patient would benefit from seeing a nutritionist and selecting an optimal and realistic dietary plan, which patient would be able to follow. We do not know how mobile this patient is, but she might benefit from the appropriate supportive bed surface as well.

This patient would benefit from a firm convexity to help stabilize the ostomy appliance and provide longer wear. Snuggly placed ostomy belt can help support the ileostomy appliance as well. A careful consideration of patient's dietary intake must be maintained. Patient would need to maintain a diet of complex carbohydrates, increasing salty foods, and limiting foods that are high

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in sugars (Carmel & Scardillo, 2022, p. 207). It is important for the patient to maintain the output for ileostomy at no more than 1500 ml and urinary output no less than 1200 ml (Carmel & Scardillo, 2022, p. 207). It is important for the patient to routinely follow up with the primary care provider to monitor labs, specifically magnesium level, B12 level, and renal function (Carmel & Scardillo, 2022, p. 207).

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)

1. Assess for pain and provide pain management as ordered
2. Change stoma pouching system every 3 days and PRN for leakage:
 - Remove the pouching system with push pull method and cleanse the skin with water. Then pat dry.
 - Measure the stoma. Previous diameter 2”.
 - Apply the Stomahesive powder as needed to any irritated skin with each pouch change, and then gently dust off the excess.
 - Apply the Cavilon skin prep
 - Allow skin to dry thoroughly for about 30 seconds
 - Apply the Hollihisive washer cut to fit as needed
 - Apply the firm convex drainable two- piece pouching system (Convatec Natura Convex-it). Opening was pre-cut to 2 1/8” in today’s visit.
 - Apply the ostomy belt snugly.
3. Clean and pat dry nearby abdominal skin folds and apply Nystatin powder to the surrounding abdominal folds with redness and satellite lesions.
4. Encourage the patient to participate in pouch changes and emptying the pouch.
5. Empty the pouch when it is 1/3 -1/2 full
6. Notify provider if stoma changes color, texture (dry, black), if there is no output, ileostomy output is greater than 1200, urinary output is less than 1200, or peristomal skin worsens.
7. Maintain strict input and output.
8. Maintain adequate fluid consumption/hydration (straw/yellow color urine) to avoid dehydration.
9. Avoid/limit foods and fluids that are high in sugars and caffeine to avoid dehydration
10. Monitor blood sugar and treat as ordered
11. Monitor blood pressure and treat as ordered
12. Maintain low air loss supportive surface on bariatric bed
13. Follow bariatric protocol per hospital policy
14. Follow up with the dietician on individualized meal plan
15. Follow up with primary care provider, endocrinologist, and cardiologist
16. Follow up with the social worker on the safe discharge plan
17. Refer to the outpatient ostomy clinic for further management of ileostomy after the discharge.
18. Refer patient to the outpatient alcohol detox/management program and smoking cessation 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:

This is the follow up visit for a 56 year old female patient who came to the ED due to weakness, fatigue, fall, and failure to maintain her ostomy appliance. Patient had a loop ileostomy creation in LUQ two months ago. Patient has a past medical history of ulcerative colitis, constipation, hypertension, uncontrolled diabetes, morbid obesity, and ETOH abuse. Patient lives with the partner. During today’s visit, patient was sitting in bed. Patient was AAOx4, calm, cooperative, and open to discussion/education and ileostomy treatment/appliance change. Patient was given pain management 30 minutes earlier as ordered. On assessment, 300 ml of liquid yellow effluent emptied from the drainage bag. Upon removal of ileostomy appliance to LUQ, moisture noted on the

back of the soft convexity barrier. Peristomal skin and stoma gently cleansed with warm water and patted dry. On assessment stoma is red, moist, round, and protruded. Stoma measured 2x2 inches. Peristomal skin is red, denuded, and irritated throughout the adhesive surface. Mucocutaneous junction is intact. Redness and satellite lesions noted on nearby abdominal folds. Stomahesive powder applied to peristomal skin and excess is dusted off. Cavilon skin prep applied on peristomal skin. Hollihesive washer applied cut to fit. Convatec Natura firm convex two-piece pouching system applied. Ostomy belt was snugly applied as well to provide extra support. Careful explanation was given to the patient and her partner during the entire pouch change. Patient held a mirror for a better visualization. Pt's partner was able to show return demonstration because patient stated she "wasn't ready to do it yet." Emotional support provided to the patient. Nearby abdominal folds were cleaned and gently dried. Nystatin powder was applied to the abdominal folds. Extra pouching systems have been left for patient, as well as ileostomy packet. Education on the importance of adequate hydration, maintaining regular pouch changes and bag emptying, keeping skin dry from perspiration and moisture, and monitoring blood pressure and blood sugar was provided. Patient verbalized understanding; however, reinforcement education is needed. Treatment and care plan discussed with nursing and the rest of the multidisciplinary team.

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 for choosing this case study was to learn how to provide holistic ileostomy care to the patient with the extensive past medical history and complicated current medical and social history. I think this case is complicated because patient is dealing with multiple physical, emotional, and psychological challenges. This patient is not doing well providing self-care, and without an appropriate care and support, her condition might worsen. This patient needs a multidisciplinary approach and regular follow-up services to help her gain control of her life. I think I was able to meet this goal because I tried to address patient's condition, select a treatment plan and a care plan that might help patient improve her quality of life.

Reference

Carmel, J., & Scardillo, J. (2022). Adaptations, rehabilitation, and long-term care management issues. In J. Carmel, J. Colwell., & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp 201-222). Wolters Kluwer.

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	✓	

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WOC nurse		
<ul style="list-style-type: none">Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
<ul style="list-style-type: none">Critical thinking utilized to reflect on patient encounter	✓	
<ul style="list-style-type: none">Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	