Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Erin Stewart Day/Date: 09/13/2025

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

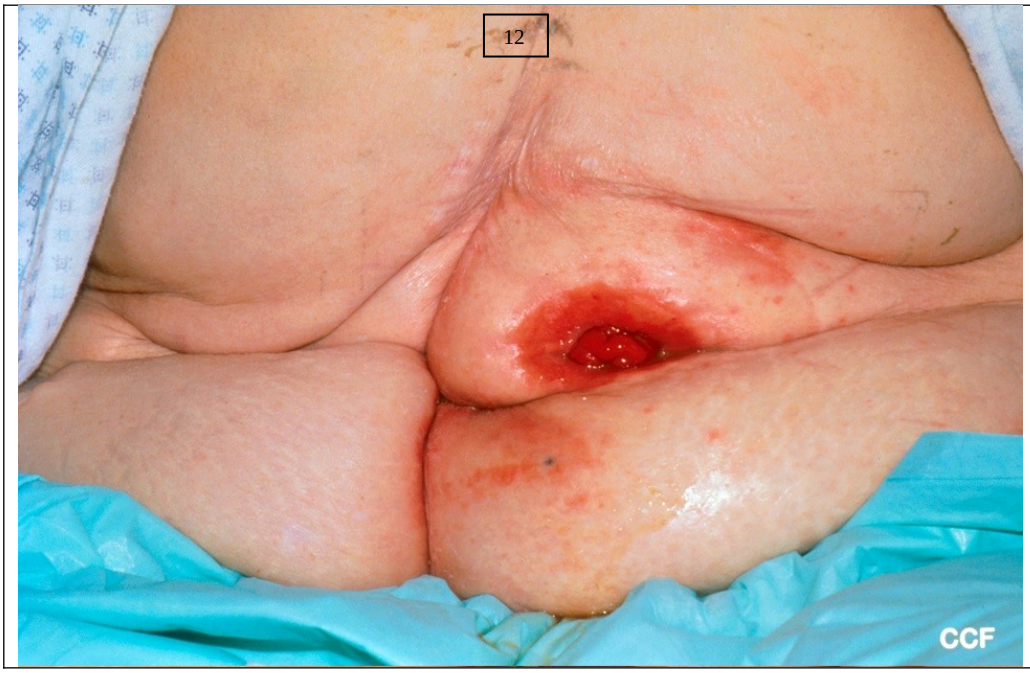
- Poor understanding of patient situation noted by the patient and significant other. Patient has a severe lack of knowledge regarding her situation.
- Patient missed previous educational appointment.
- Resistant to education until her pain and output are controlled.

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.

In addition to what was already assessed for this patient, I would also assess how firm or not firm the area of the abdomen is because since this stoma is flush it will need a convex skin barrier but I need to know just how flexible or not flexible it should be. I would also ask the patient when she started having high output and also ask her about what she had been eating, what her diet looks like. I would also investigate about the stoma marking tattoo that is able to be visualized lower down on her abdomen, since she has had multiple bowel resections and abdominal surgeries could it be that the bowel could not reach that lower stoma mark or whether it was a mark from a previous ostomy. I would also assess the patient's stoma while she is sitting and while she is standing to get an idea of the topography of her abdomen and how the stoma sits in each position. I think a lot of this patient's issue is lack of education regarding and ileostomy vs a colostomy but also not having the correct stoma supplies and regimen for this particular ostomy. After getting this patient squared away with pain control at least I would talk to her about educating her while I put on her ileostomy appliance and what I use, how I use it, and where I put each accessory for a good seal. Afterwards I would most likely consult plastics to see if there might be anything that can be done to help with the scarring causing the abnormal topography of her abdomen in order to try to minimize the extra folds created by the scars, however I would only do this if the patient wanted me too, while fitting this ostomy would be difficult it's not impossible and could possibly make pouching this ostomy a lot easier and less stressful on the patient. I would definitely provide thorough education to this patient regarding care of her ileostomy and educate on how it is different than a colostomy and how they are treated differently and have different guidelines and diets but especially talking to her about how alcohol can increase output from her ileostomy as well as how it affects the body negatively anyways. I would also talk to her about the importance of keeping hydrated when you have a high output ileostomy due to the risk of severe dehydration, and I would also provide her recipes for rehydration drinks that she can make and use at home and give her a few different ones so that she can figure out which one works best for her. Lastly I would ask the patient about how often she's had to empty her pouch while at home but most especially while in the hospital since there has been no output recorded since the patient's ED admission.

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)

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Ileostomy Appliance Change every 5-7 days. Remove old appliance and cleanse the stoma, peristomal skin, in skin folds, and skin that is reddened due to contact with effluent and pat dry. Apply Convatec Esenta Sting-Free Barrier Wipes to the peristomal skin and any skin that will be under the skin barrier wafer; apply Convatec stomahesive powder to the reddened and denuded areas then brush off any excess; apply Coloplast Brava ostomy strip paste to the skin folds at 9 o'clock and 6 o'clock using it to fill in the folds to create an even surface; apply convatec stomahesive uncut skin barrier cut into a petal shape and place around the stoma so that the stoma looks like a flower with the stoma itself as the middle of the flower; Apply convatec sur-fit natura two-piece durahesive skin barrier with convex-it technology 2 ¼ inch flange with 2 inch precut stoma opening to the stoma; then apply sur fit natura two-piece high output pouch with 2 ¼ inch flange making sure that the spout is closed and then attach the convatec ostomy appliance belt adjusting it to fit.

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:

Follow-up visit for patient with high output ileostomy and ill-fitting appliance due to using old colostomy supplies and not filling her post-op ostomy order. Patient seen after being admitted to the medical surgical floor from the ED. Educated the patient on the differences between a colostomy and an ileostomy especially regarding high output of liquid effluent. Went over diet and what to avoid eating or what to change how it's eaten while having an ileostomy. Went over with patient how dehydration and acute renal problems can occur with a high output ileostomy and recognizing the signs of them and also how to prevent and recognize a food blockage. This patient has had an ostomy before albeit a colostomy rather than an ileostomy, so pouching basics were verbally gone over. Patient was educated on pouching her current ileostomy by talking about what each accessory is used for and how they are being used for her ileostomy pouching and then showing her how to apply the appliance and accessories for her particular stoma. The patient was educated on keeping follow-up appointments and that if she is having any trouble with her pouching system to call and/or make an appointment to be seen in the ostomy clinic so that the problem can be addressed and troubleshooted.

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 was to really stretch myself because trouble shooting leaking ostomies in not my strong suit due to having only 2 patients with ostomies at the facility I work at and both of them having very easy and dependable appliance regimens. I think I was able to meet this goal but I'm not sure if I might have gone a little bit overboard with trying to protect from leakage since this patient has so many rolls and scars making it a more difficult to pouch ostomy.

Reviewed by: _____ Date: _____

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CRITICAL ELEMENTS	Completed	Missing
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• 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	✓	