

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

Virtual Journal Entry with Plan of Care & Chart Note

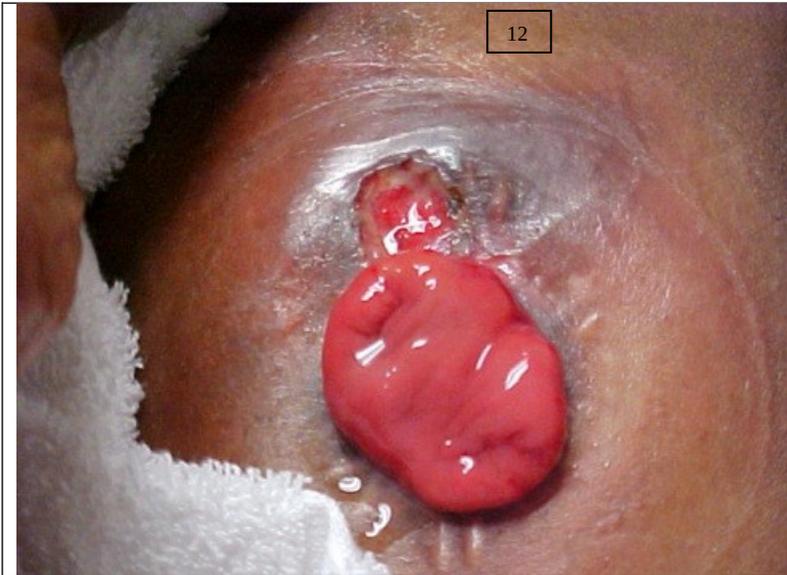
Student Name: Alice Pownall-Gray Day/Date: 10/26/2025

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.

<p>Chart Review/History</p>	<p><u>Age/sex</u>: 37-year-old female</p> <p><u>PMH</u>: 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.</p> <p><u>CC</u>: Pain under ostomy appliance.</p> <p><u>Meds</u>: Methotrexate, Prednisone, Sertraline, Hydralazine, Vicodin PRN, Tylenol PRN, Over the counter Probiotic</p> <p><u>Social hx</u>: Denies smoking, ETOH or illicit drug use</p> <p><u>Labs</u>: Labs drawn at last outpatient appointment and unremarkable.</p> <p>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.</p>
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<p>Assessment/encounter:</p> <p>Ostomy nurse visit today in the outpatient clinic.</p> <p><u>LOC</u>: Patient awake and alert</p> <p><u>Interview</u> with patient</p> <ul style="list-style-type: none"> • 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 <p><u>Stoma</u>: Loop ileostomy, pink, moist,</p> <p><u>Stoma size</u>: 1.3x 1.0"</p> <p><u>Shape</u>: round</p> <p><u>Peri-stomal skin</u>: full thickness wound at 12 o'clock aspect noted with heavy serous drainage and violaceous edges.</p> <p><u>Abdominal plane</u>: semi-soft, flat, painful on palpation.</p> <p><u>Education</u></p> <ul style="list-style-type: none"> • Develop education below <p>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.</p> <p><i>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.</i></p> <p>Photo</p>



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 want to know if the patient has a history of pyoderma gangrenosum. Would like to know if the patient has been using any topical steroids to the open wound area? Has she seen dermatology and has she a biopsy to this area.

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)

Due to the location and the patient's history of Crohn's
Treatment of peri stoma ulcer wound to include:
Oral pain medication as needed prn prior to appliance change
Order for with use of lidocaine to ulcer prior to dressing change if needed.
Gentle cleanse to ulcer with soap and water, then dry and apply ostomy powder then skin pep
Cover with silver ag then cover with hydrocolloid
Cover gently with wafer and appliance

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:

Pt with a history of active inflammatory bowel disease. Pt has a peristomal ulcer. After the assessment of the ulcer, the patient description of pain and consideration of the pt medical history, the ulcer is highly suspicious for pyoderma gangrenosum, referral to dermatology for biopsy.
Treatment of peri stoma ulcer wound to include:

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Oral pain medication as needed prn prior to appliance change, oral steroids if prescribed
 Order for with use of lidocaine to ulcer prior to dressing change if needed.
 Gentle cleanse to ulcer with soap and water, then dry and apply ostomy powder then skin pep
 Cover with silver ag then cover with hydrocolloid
 Cover gently with wafer and appliance
 Pt education:
 Report any increased pain redness fevers
 Continue oral pain meds as needed
 Continue oral steroids if prescribed

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?

Ostomy experience and how to care for pyoderma grangrenosum.

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	✓	