

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

Virtual Journal Entry with Plan of Care & Chart Note

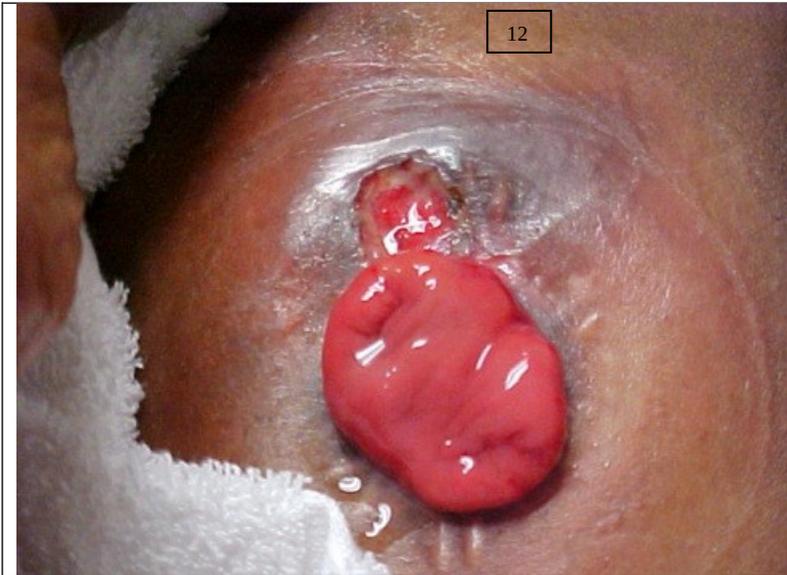
Student Name: Terryann Simpson Day/Date: 12/30/2025

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 the environment. Patient was experiencing symptom exacerbation related to her diverticulitis diagnosis, to which she went to the ER 8 weeks ago. Workup discovered severe adhesion, and the patient had a RUQ loop ileostomy placed with a bowel resection.</p> <p><u>CC</u>: Pain under the 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.

The patient presented with a new wound and pain. My initial assessment would include pain rating, skin temperature, and wound measurement (length, width, depth). Due to the presentation of the wound edges and the color of the surrounding tissue, I would assess for any tunneling or boggy tissue in that area, blanching, and odor. The length of time she has had this wound, what treatment she has tried already, physical assessment of the patient, vital signs, A1C and blood sugar because of her steroid use, and assessment for any fever, chills, and fatigue, as well as a list of allergies.

The Patient is currently on steroids, which will contribute to poor wound healing. Ileostomy is also noted for high output, and effluent will cause damage to the surrounding skin, so when she is there for her wound, I would also assess for intake and output amounts, labs to assess for electrolyte imbalance, as well as diet.

The patient will be returning home; she will need a home care referral for a nurse to evaluate and monitor the wound. She has an ileostomy, and her diet will differ significantly from before surgery, so she will also need a dietary consultation to make sure she understands her new normal, has adequate nutrients, stays hydrated, and prevents any blockage of her ileostomy while promoting wound healing. The patient will be given baseline education on diet, including high-protein, electrolyte-rich, zinc-rich, and low-fiber options, before leaving the clinic today.

The stoma is looking great, and no concerns for the stoma or stoma output currently. Because of her history of depression and her current wound and pain, I would also assess her coping and mental health to see if she needs a referral to mental health. Biopsy and culture wound bed to rule out other causes of the wound.

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)

Clean the wound with normal saline, pat dry, and complete a dressing change as follows:

Cut Conva Tec AQUACEL Ag Advantage Antimicrobial Dressings to fit the wound bed and apply directly to the wound bed only, gently/loosely packing the wound, changing every 3 days and as needed.

Cover wound with Smith and Nephew Allevyn adhesive foam dressing and change every 3 days or as needed.

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Measure ileostomy and cut SenSura Mio Extended wear Maxi drainable pouch with soft outlet flat, change every 3 days and as needed.
Return to the wound clinic in 2 weeks for a wound check
Consult with homecare agency for wound management
Consult with Dietary for education to promote wound healing and ileostomy management.
Continue to follow up with your Rheumatologist

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:

37 year 37-year-old female presented to the clinic for evaluation and management of a wound around her ileostomy site. The patient recently had a loop ileostomy in the RUQ over 8 weeks ago due to bowel adhesion. She has a history of Crohn's, diverticulitis, bowel resection, ileostomy placement, hypertension, rheumatoid arthritis, and depression. She reports that her wound started out as a pinpoint area that erupted into a very painful wound with lots of drainage, which is causing her to change her appliance every 1-2 days.

Wound assessment showed a wound with a moist wound bed that is clean and red, with serous drainage, ragged edge, and a blue/violet border. Current medications include Methotrexate, Prednisone, Vicodin PRN, and Tylenol PRN. She is rating her pain as a 10/10, no fever or chills, vital signs stable.

Punch biopsy was completed using a 4mm punch taken from the 9 o'clock position of the wound, and wound culture was collected using a swab and both were sent to the lab to rule out other contributing factors to the wound. Based on the patient's medical history, medications, and presentation, the differential diagnosis includes pyoderma Gangrenosum. Patient will follow up with her rheumatologist to continue her steroid management.

Wound care and ileostomy changed completed. And she tolerated it fairly. The wound was cleansed with normal saline, patted dry, and a dressing change was performed as follows:

Cut Conva Tec AQUACEL Ag Advantage Antimicrobial Dressings to fit the wound bed and apply directly to the wound bed only, gently/loosely packing the wound, changing every 3 days and as needed.

Cover wound with Smith and Nephew Allevyn adhesive foam dressing and change every 3 days or as needed.

Measure ileostomy and cut SenSura Mio Extended wear Maxi drainable pouch with soft outlet flat, change every 3 days and as needed.

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 the ability to gain more knowledge by doing my own research and looking at a different possible cause of her wound based on presentation and location. This allowed me to create a treatment plan for this patient, identify the cause of the wound, prevent any further skin damage, and help to alleviate her pain. Yes, my goal was met in this assignment.

Reviewed by: _____ Date: _____

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CRITICAL ELEMENTS	Completed	Missing
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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	✓	