

Virtual Journal Entry with Plan of Care & Chart Note

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 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>: 14-year-old female</p> <p><u>PMH</u>: severe ulcerative colitis. PMH of UC, rectal bleeding, malnutrition and failure to thrive. Patient is amenorrheic. No further significant history. Patient active in sports previously and has been unable to participate this year. Reported unmanageable UC symptoms x 2 years that were beginning to affect her schooling. Reported up to 20 bowel movements per day and “unmanageable” abdominal pain. Medical management of UC has been unsuccessful. Patient and parents agreed upon surgical intervention to try to regain quality of life. Pt received pre-operative education and stoma site marking in outpatient clinic prior to surgery for IPAA. Three step surgery indicated due to present severe malnutrition. Underwent 2nd step of 3 step IPAA with loop ileostomy two days ago.</p> <p><u>CC</u>: UC, Post op IPAA step 2</p> <p><u>Medications</u>: IV morphine (PCA)</p> <p><u>Social hx</u>: Denies smoking, ETOH or illicit drug use. Patient parents are very involved in care. Patient's mother does not want the patient to see her new stoma and states she will be the primary caregiver. It is documented that she has expressed concerns regarding the availability of nursing staff at the patient's school, as the patient will be returning soon.</p> <p><u>Labs</u>: Na 135, K 4.8, Cl 100, BUN 10, Glu 79, WBC 8.0, Hgb 8.8, HCT 29.9.2 %, PLT 251</p>
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Assessment/encounter:

Ostomy nurse consulted for routine post op day 2 assessment

LOC: Patient sleeping in bed. Mother, at bedside, anxious. Patient aroused easily but sleepy, medicated.

Interview with the mother who states the patient

- Has been having “10/10” pain managed with ordered medication
- Has not ambulated since surgery
- Has had “black poop come out already”
- Had a pouch leak last night that the she (the mother) “fixed” with copious amounts of ostomy paste
- Has many concerns regarding leaking

Stoma: Budded, moist, red, edematous. Rod noted in place.

Stoma size: 2.0 x 1.5 in

Shape: oblong, edema noted, both lumens visualized

Peri-stomal skin: Intact. No erythema or denuded areas noted.

Abdominal plane: semi-soft, edematous, smooth and flat. Post op pouch appears to have creased when the patient sat up.

Pouch:

- Coloplast Sensura post operative drainable ostomy appliance
- In place to RLQ with dark green effluent in pouch and on abdomen

Education

- o Develop in plan below

Patient has no immediate discharge plans at this time.

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



12

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.

This is a 14-year-old who went through a major body and life-changing experience, and sensitivity and education need to be delivered carefully. The patient's mother is doing most of the care and does not want the patient to see the stoma site. This is a concern as the patient is old enough to participate in her own care with proper education and practice. To start, assess why the mother does not want the patient to see the ostomy from her perspective. Then find out from the patient's perspective what her concerns are; this will open the door for providing the proper support where needed the most, and education.

The patient is of school age and will be returning to school, so the sooner the adjustment process starts, the better prepared she and her family will be. Education will be delivered in small segments each day using hands-on care as well as written materials, and will build on each day while assessing progress and acceptance. The goal is that by discharge, she will be able to empty her own pouch and will be able to assist in changing her ostomy.

Labs need to be assessed for fluid and electrolyte imbalance; her Hgb is only 8.8, which is low, she does not need a blood transfusion at this point, but the goal is for it not to go any lower, so iron infusion might be best for her. Pain assessment and medication management, assess if pain is managed effectively by Morphine. The patient is sleepy, but the pain is 10/10. If her pain is not managed effectively, she will not be able to function or participate in her care, and this will slow her recovery. Discuss with the provider if there is another alternative for medication that could give her more adequate relief for a longer duration.

She needs a physical and occupational therapy evaluation. It is day 2 post-op, and she has not gotten out of bed yet. The longer she is in bed, the more setbacks she will have for her recovery. Assess why she has not gotten out of bed and educate her and her family on the importance of mobility to recovery, such as improvement in mobility, strength, and respiratory function. She will also need to have a dietary consultation for her malnutrition and ileostomy. Dehydration is more common in this type of procedure because of its high output, and the patient and family should be made aware. Adequate hydration through IV fluids while still hospitalized is essential, and transition to oral intake as soon as permitted. Also, assess if the patient is voiding based on the location of surgery in the pelvic area this could be an issue.

It is time to assess the stoma, as it is 2 days post-op, and she is experiencing output. The stoma and peri-stomal skin are in appropriate and expected conditions. The current color of the stool is normal and will also change based on what the patient eats. Educate the patient and her family about concerning stool colors, such as black or tarry, bright red, yellow, and pale white or grey; they need to notify the provider or wound care nurse. The pouch leaked overnight and had a crease when the patient sat up; this is also an issue.

Pouch change demonstration is completed with patient and family involvement. More paste does not make a better seal; ileostomy stool is liquid because of the removal of the large intestine, so this is expected. The goal is to prevent denuded skin and extend wear time. The best type of ostomy appliance for this patient would be a soft convex pouching high-output appliance that can be attached to a drainage system overnight. Her abdominal plane is smooth, semi-soft, and flat; the current pouch creases when she is in a sitting position. A soft convex will bend and move with her body; a deep convex might cause mechanical skin damage when she is in a sitting position.

The pouch should be emptied when it is 1/3 or 1/2 way full to reduce the pressure on the stoma and increase wear time. The patient should also know that the rod will stay anywhere from 3-14 days to stabilize her stoma. Acknowledge her two lumens, noting that one is for stool and the other is for mucus because of her temporary rectal bypass.

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)

Remove the current appliance, cleanse the stoma site with warm water, and complete pouch change as follows:
Measure the stoma and cut the stoma appliance aperture to fit around the stoma to prevent leakage or stoma strangulation.
Apply Coloplast SenSura Mio extended wear MAXI drainable one-piece transparent pouch with soft convex and change every 3-5 days and as needed.
Apply the ostomy appliance to the drainage system at bedtime.
Upon discharge from the hospital, follow up with the ostomy clinic outpatient within 2 weeks
Consult home care for ostomy management when discharged
Measure ostomy output to monitor for fluid imbalance
Consult with physical and occupational therapy for evaluation during hospital admission
Dietary consultation for malnutrition and ileostomy appropriate diet

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:

Patient was seen today for an initial evaluation by a WOC nurse post-op loop ileostomy placement related to ulcerative colitis, stoma is in her RUQ, peri-stoma skin intact without denuded areas, abdomen is semi-soft, smooth, flat, and edematous. Ostomy is budded, moist, red, and edematous. Rod is in place, and both lumens are visible. She is a 14-year-old female with parents present at the bedside during assessment.

Her history includes severe ulcerative colitis, rectal bleeding, malnutrition, failure to thrive, and amenorrhea. Current labs include Na 135, K 4.8, Cl 100, BUN 10, Glu 79, WBC 8.0, Hgb 8.8, HCT 29.9.2 %, PLT 251. IV Morphine via PCA pump. Her family had concerns for pouch leakage, pain, and concerns for her returning to school with her new ileostomy. Patient and family were assessed for their readiness to learn as well as their fears. The writer spent time covering dietary education, pain management, the role of physical and occupational therapy in the recovery process, as well as mobility.

Ostomy measurement completed, appliance changed from flat to soft convexity to prevent skin damage and promote wear-time. The stoma aperture was cut with approximately 1/8 cm margin away from the stoma to prevent stoma strangulation or leakage under the appliance. Coloplast SenSura Mio extended wear MAXI drainable one-piece transparent pouch with soft convex was applied, and the option to apply a night-time drainage bag. She tolerated the procedure well.

Patient educated on foods that can cause blockage, such as nuts, corn, coconut, mushrooms, celery, Chinese vegetables, and skin from fruits. She was also educated to advance diet as tolerated and divide into small meals, and sip liquids slowly and consistently throughout the day, and electrolyte replacement options. Patient and family questions and concerns were addressed. Will discuss with discharge planning and the surgeon on a tentative discharge date. WOC nurses continue to evaluate the patient daily until discharge, with a plan to consult a home care nurse and order appropriate supplies before the patient's discharge.

Braden Scale: Sensory perception = 4, moisture = 4, activity = 1, mobility = 4, nutrition = 1, friction and shear = 3, with a total score of 17. The patient has no limitation in perception, encouraged to verbalize pain and discomfort. Report any moisture concerns to prevent skin breakdown. Patient was given a 1 for activity because even though she can get up and walk, she has not done so in 2 days, so this warrants an evaluation from PT/OT to prevent falls, monitor balance, and endurance. Once she is evaluated by PT/OT, encourage frequent mobility and ambulation as tolerated. Nutrition is also 1 because of her malnutrition, failure to thrive, and recent ileostomy, which increases her risk of poor nutrition. A dietitian was consulted to assist with the management of this, encourage fluid intake as tolerated, offer a nutritional supplement, and water as ordered. Record intake and output.

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?

I chose this case because of its different components, the opportunity for me to learn while providing essential education and services to support the patient and her family for a successful transition. Yes, goals were achieved. At the end of the visit patient and family were more comfortable, supported, and they had a plan in place going forward. While pre-op education is very important, the post-op education piece is more valuable because now everything becomes real, and patients have more questions than answers.

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	✓	



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Thoughts Related to Visit:		
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	