Ileostomy with a written hydration plan: advice

Assume that today's date is 5 November 2026. You have reviewed Ms Alwine Naser at home. This is original independent practice material with fictional patient details and care arrangements. You are a registered nurse in the stoma service. Using the case notes, write to Ms Alwine Naser's agreed adult son, Mr Brian Melvin, confirming his agreed support, explaining her individual written hydration plan and outlining when to seek help. A copy of the plan will accompany your letter; its complete instructions are recorded below. Address the letter to Mr Brian Melvin, Flat 2, 18 Orchard Road, N1 7AB. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Ms Alwine Naser	☐	☐	☐
2. DOB: 14/03/1961 (65 yrs)	☐	☐	☐
3. Discharged 02/11/26; home review today, 05/11/26	☐	☐	☐
4. Agreed helper: adult son, Mr Brian Melvin (38)	☐	☐	☐
Social background			
5. Lives alone; independent with personal care	☐	☐	☐
6. Son nearby; available evenings, not during working hours	☐	☐	☐
7. Patient consents to son receiving these instructions and helping with diary	☐	☐	☐
8. Retired administrator; enjoys collecting old postcards	☐	☐	☐
9. Son already knows operation details; attended discharge teaching	☐	☐	☐
10. Complained that ward staff took too long answering bells	☐	☐	☐
Medical history			
11. Ulcerative colitis diagnosed 2014	☐	☐	☐
12. 22/10/26: subtotal colectomy and end ileostomy	☐	☐	☐
13. Appendicectomy 1989; uncomplicated recovery	☐	☐	☐
Home assessment			
14. Alert, comfortable; eating regularly; urine unchanged from usual	☐	☐	☐
15. Stoma pink; surrounding skin intact; pouch secure	☐	☐	☐
16. Soft output; no recent ↑; no vomiting or abdominal pain	☐	☐	☐
17. Demonstrated independent pouch emptying and changing	☐	☐	☐
18. Occasionally forgets drinks when busy; requests reminders, not takeover	☐	☐	☐
Individual plan and agreed support			
19. Treating-team written plan supplied: regular drinks throughout day; record drinks and output amount/consistency; no fixed litre target set	☐	☐	☐
20. Son agrees evening visits for first week: check supplies, prompt plan adherence, help complete diary	☐	☐	☐
21. Ask stoma team before changing hydration plan; no independent fluid targets	☐	☐	☐
22. Measuring jug, diary and spare pouches available	☐	☐	☐
Safety advice reinforced			
23. Contact stoma team via hospital switchboard promptly: markedly ↑/watery output, repeated leakage or sore surrounding skin	☐	☐	☐
24. Dry mouth, unusual tiredness or ↓ urine → urgent GP/NHS 111 advice; inform stoma team	☐	☐	☐
25. Severe abdominal pain OR vomiting → immediate GP/NHS 111 advice; either symptom alone sufficient, even without ↓ output; do not await routine review	☐	☐	☐
26. Confusion or difficult to wake → call 999	☐	☐	☐
Follow-up			
27. Stoma review 09/11/26; bring diary for individual reassessment	☐	☐	☐
28. Patient requests written reminder for son; plan copy enclosed	☐	☐	☐
29. Son has arranged transport to review	☐	☐	☐
30. Prefers reading newspaper before breakfast	☐	☐	☐