

Discharge to the community nurse: new colostomy in an older man living alone



Assume that today's date is 23 October 2026. Mr Varley is being discharged home this afternoon. You are a registered nurse on the surgical ward. Using the information in the case notes, write a letter to Ms Abena Upton, Nurse Unit Manager of the District Nursing Service, requesting continued care for Mr Varley at home. Address the letter to Ms Abena Upton, Nurse Unit Manager, District Nursing Service, 42 Mill Lane. 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).

Patient details

1. Name: Mr Ferdinand Varley
2. DOB: 09/05/1950 (76 yrs)
3. Address: 14 Orchard Street
4. Admitted: 12/10/26 (via ED); discharge: 23/10/26

Social background

5. Widower; lives alone in 2-storey house; bathroom upstairs
6. Daughter lives 2 hrs away, phones daily; neighbour helps with shopping
7. Retired carpenter; keen gardener, asking when he can return to his vegetable patch
8. Daughter reports pt's brother 'hasn't spoken to him in years'

Medical history

9. Diverticular disease (dx 2019)
10. Hypertension: amlodipine 5 mg daily
11. Osteoarthritis both hands: ↓ grip & dexterity; difficulty cutting & peeling stoma appliances
12. Bilateral cataract surgery 2020; vision adequate with glasses
13. Appendicectomy aged 12
14. Allergies: penicillin (rash)

Admission

15. Perforated sigmoid diverticulitis with peritonitis
16. 12/10: emergency Hartmann's procedure (laparotomy) → end colostomy LIF
17. Post-op IV antibiotics completed 19/10; afebrile; eating & drinking normally
18. Complained food 'tasteless'; asked to speak to ward manager

Stoma

19. End colostomy LIF: pink, moist, healthy; diameter 35 mm; mucocutaneous junction intact
20. Peristomal skin intact, no redness

Stoma

21. Output: soft formed stool 1-2 x daily; passing flatus
22. Appliance: one-piece drainable, cut-to-fit (currently cut to 35 mm); pt unable to cut aperture due to hand OA → nurse to cut & fit; change every 2-3 days or if leaking; switch to pre-cut once size stable
23. Empties bag independently; needs assistance to remove & apply appliance
24. Initially reluctant to look at stoma; now anxious but participating in care

Wound

25. Midline laparotomy wound: clean, dry, healing; clips in situ
26. Clips due for removal 26/10
27. Advised no heavy lifting 6/52; gentle walking daily

Discharge medications

28. Paracetamol 1 g QID PRN for pain; amlodipine unchanged

Discharge plan

29. Stoma supplies for 2/52 given; registration with stoma supply scheme completed
30. Community nursing 3 x/wk from 24/10 for 2/52: assist with appliance changes, check stoma & peristomal skin, review wound, remove clips 26/10; teach pt to change appliance; measure stoma at each change & adjust aperture (size ↓ over first weeks); once size stable, liaise with stoma nurse re pre-cut supply
31. URGENT: new dusky/dark stoma → contact surgical team immediately for urgent assessment; if prompt surgical review not available → ED; no output + abdo pain/vomiting → urgent medical assessment; severe pain or deterioration → ambulance/ED. Routine: retraction, peristomal skin breakdown, signs of wound infection → stoma nurse/GP
32. Stoma nurse phone review 30/10
33. Surgical OPD 6/52; possible reversal to be discussed at review