

## WOC Complex Plan of Care

Name: Wendy Kye

Date: 05/17/2023

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
<p>68 year old postmenopausal female with bladder cancer discovered during a cystoscopy. Biopsy results indicated malignancy. Patient underwent radical cystectomy with ileal loop urinary diversion. Patient seen pre-operatively and stoma site marked. Being seen today, POD 1, for ostomy evaluation and teaching.</p> <p>PMH: bladder cancer, chronic UTI, CKD, diabetes mellitus, hypocholesteremia, hypertension, migraines, mitochondrial disease, obesity, polycystic liver disease, spinal stenosis, thyroid nodule, tinnitus, breast cancer.</p> <p>Surgical History: breast lumpectomy (2018, 2019), cystoscopy (2018), dilation and cutterage, exploratory laparotomy.</p> <p>Home medications: Anastrozole, Atenelol, Basaglar Insulin, Cardizem, Chlorpheniramine, Chromium Picolinate, Cinnamon, Cranberry, Desipramine, Diphenhydramine, FeroSul, Fluoxetine, Fluticasone inhaler, Gabapentin, Gemfibrozil, Hydrocodone, Lasix, Losartan, Novolog Flex pen, Omega-3, Tamsulosin, Vitamin B12, Vitamin D3.</p> <p>Allergies to Atorvastatin and Sulfa.</p> <p>Patient sitting up in bed utilizing pillows for abdominal splinting. Patient instructed on visit plan and agreeable. Hollister two piece cut to fit 2 ¼” urostomy pouching system in place to RUQ loop urostomy. Light red colored urine in small amount noted in pouch. Two stents visible; one red, one blue. Bilateral JP drains in place to RLQ with serosanguineous drainage noted in bulb drainage collectors. Midline abdominal incision with intact island dressing, minimal amount of serosanguinous strike through drainage noted. Pt voices has had episodes of fecal incontinence. States “I feel like I am leaking stool”. Patient agreeable to dressing changes and ostomy teaching. Urostomy appliance removed. Peristomal skin intact and without irritation. Mucocutaneous junction intact with visible sutures. Stoma beefy red in color, moist, and protrudes approximately ½ inch above skin level. Round in shape. Peristomal skin and stoma cleansed with water. Patted dry. Utilizing gauze pads to manage drainage from ureters. Stoma measures approximately 2 in utilizing measuring guide. Appropriate size opening cut in skin barrier wafer. Stoma and stents fed through skin barrier wafer opening. Pouch snapped onto flange. Explanation of appliance change provided with demonstration. Pt attentive. Questions answered to pt satisfaction. Pt encouraged to assist with emptying pouch. Additional appliance left at bedside for pt to practice applying and removing pouch from skin barrier wafer. Midline incision dressing removed. Incision measures 15 cms x 1 cm x 0.25 cms. Periwound without induration, redness, irritation. Surgeon at bedside at time of dressing removal and</p>	<p>WBC 8.1            RBC 4.03  Hgb 12.0           Hct 36.1  Sodium 137        Potassium 3.6  Chloride 99        CO2 25  Anion gap 13      Glucose 98  Calcium 9.1  Magnesium 1.5   Phosphorus 3.7  Total protein 6.5 Albumin 3.7</p> <p>Height 160.02cm  Weight 97.7kg  BMI 38.1</p> <p>Vitals:  HR 66  Temp 99.1  BP 110/60  SaO2 97% room air  Finger stick glucose 101</p> <p>Pre-op CXR: unremarkable  Pre-op EKG: normal findings</p> <p>Abdominal CT: taken but report unavailable</p>

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<p>aware of clinical findings. Site cleansed with NS. Dressing hydrogel impregnated gauze applied to wound bed. Covered with ABD dressing. Secured with silicone tape. Reinforced need for splinting with coughing and possible future need for an abd binder. Pt verbalized understanding. Pt states her abd is “tender” and is challenged to splint when coughing and to splint while repositioning. Encouraged to seek assistance of nursing with repositioning, deep breathing. Verbalized understanding. Perineal/perianal assessment notes anal area slightly red, blanchable, and without satellite lesions. Discussed use of soft clothes and/or peri bottle for cleansing. Skin barrier ointment left in room for use prn. Discussed possible use of BSC. Verbalized desire to not have this time. States “I will try the wipes and barrier first and check myself more frequently.” Identified foods which might help to thicken stool when able to ingest. Verbalized understanding. WOC Services to follow and continue to provide ostomy, wound and continence support.</p>	
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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
<p>Alter urinary function 2/2 new urostomy placement.</p> <p>RUQ loop urostomy</p> <p>Light red colored urine in pouch, two stents one red, one blue</p> <p>Peristoma skin intact without irritation. mucocutaneous junction intact with visible sutures.</p> <p>Stoma beefy red in color, moist, protrudes about ½ inch above skin level, round, measures 2 in.</p>	<p>Nursing to monitor labs and notify provider with the results K&lt;3.6 &amp; &gt; 5, mg &lt; 1.8 &amp; &gt;3, Na &lt; 134 &amp; &gt; 144, Cl &lt; 98 &amp; &gt; 107, Bicarbonate &lt;21 &amp; &gt; 28, Total Protein &lt; 6.5 &amp; &gt; 8.2, Albumin&lt; 3.5 &amp; &gt; 5, concern for metabolic acidosis and malabsorption.</p> <p>Notify provider BP &gt; 170/90 &amp; &lt;100/60, HR&gt; 110 &amp; &lt; 60, RR &gt; 30 &amp; &lt;10, Pox &lt; 93, Temp &gt; 102.</p> <p>Notify provider BG &lt; 90, &gt; 120</p> <p>Consult pharmacist to review medications.</p> <p>Removed urostomy appliance carefully using the push-pull method.</p> <p>Cleanse the peristoma and stoma with water and soft cloth, patted dry.</p>	<p>Patient attentive during demonstration and explanation of appliances removal and pouching system change, questions answered to patient’s satisfaction.</p>	<p>To correct any electrolyte imbalance &amp; prevent complications. Urostomy are prone to hyperchloremic metabolic or metabolic acidosis and malabsorption (Carmel &amp; Scardillo, 2022)</p> <p>Keep other medical conditions under control promote wound healing by prevent the damage and inhibition the conditions can cause.</p> <p>Medications can contribute to a host of compromising healing issues a review can reveal (Beitz, (2022).</p> <p>To prevent peristomal and stoma skin damage. To manage urine, draining for stents once pouch is removed.</p> <p>Need to measure at each pouching system change to prevent cutting the stoma opening on wafer to large that may damage peristomal skin and stoma (Carmel &amp; Goldberg, 2022).</p>

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	<p>Used gauze for drainage from ureters stents.</p> <p>Learn the normal appearance of healthy stoma and peristoma skin: beefy red in color, moist, round, protrudes about 2cm above the skin, location of the os (stoma opening), mucocutaneous junction intact, peristomal skin intact.</p> <p>If stoma dark red to purple could have a low vascular issue and should contact surgeon.</p> <p>Measure stoma at each pouching system change for at least 4 to 6 weeks after surgery because of stoma swelling decreases, until stoma size stabilizes by remaining the same size for 4 changes. Using measuring guide include with pouching system. System change occur every 3 days.</p> <p>Learn urostomy pouch system Hollister two piece cut to fit 2 1/4 urostomy pouching system.</p> <p>Alternative ostomy appliance: Coloplast Assura two-piece urostomy pouch, cut to fit, extended wear.</p> <p>Cut skin barrier wafer 2 inch to fit around stoma. Carefully feed stents and stoma through opening cut on skin barrier. Gently connect pouch to the skin barrier hear the snap, use the lip on the skin wafer to avoid pressure on the abdomen.</p> <p>Assist with urostomy pouch emptying</p>	<p>Gentle to prevent pain and discomfort by avoid firmly pressing on abdomen. Two-piece wafer have lip to attach pouch to skin wafer (Colwell. &amp; Hudson, 2022a and Colwell. &amp; Hudson, 2022b).</p> <p>Patient's stoma protruding ½ in (1.27cm) above skin level may cause urine to collect under the skin wafer leading to stoma and skin complications (Colwell. &amp; Hudson, 2022a). Gently place wafer over stoma and stents not dislodge, damage stents or stoma.</p> <p>To become comfortable with connecting and disconnecting pouching system. Also, become familiar with the pouching system.</p> <p>To know when to seek medical assistance, urinary diversion surgery may change the signs of a UTI (Carmel &amp; Scardillo, 2022).</p> <p>No special diet, staying hydrated and cranberry juice or capsules keep urine acidic preventing urinary calculi and infections (Carmel &amp; Scardillo, 2022). To assess the patient's needs, to maintain nutrition.</p> <p>Water, soap, and air will not harm the stoma (Carmel &amp; Goldberg, 2022). Regarding the abdominal incision possibly after 48 to 72 hours may allow showering (Brindle &amp; Creehan, 2022).</p> <p>Adequate hydration with urostomy to prevent infection (Carmel &amp; Goldberg, 2022).</p> <p>Normal appearance of urine output and</p>
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	<p>each time it is performed. Tomorrow Tuesday morning on my next visit you will perform urostomy pouch emptying. Know when emptying is needed when ½ or 1/3 full.</p> <p>Two-piece urostomy pouching system left at bedside to practice connecting the pouch to skin wafer and disconnecting the pouch from the skin wafer for 5 minutes, 4 times a day.</p> <p>You will change the next pouching system in two days on Wednesday or earlier if the pouch needs changing.</p> <p>Continue cranberry capsules, maintain adequate hydration 1500 to 2000ml throughout the day. Consult Dietitian treatment and evaluation.</p> <p>Learn urostomy output normal appearance: urine pale yellow with mucous shreds. Normal to see a larger amount of mucous for a few months following surgery.</p> <p>Attach a drainage bag at night, hang to gravity, change every 14 days.</p> <p>You may shower or bath with or without pouch once cleared by surgeon or incision has healed. Thoroughly dry stoma.</p> <p>You may continue to wear pervious clothing if not restricting urostomy like too tight, belt placed across stoma.</p> <p>Activity: do not lift over 10 pounds.</p>	<p>The patient able to demonstrate and teach</p>	<p>using drainage bag at night to prevent over filling pouch during the night, and to prevent infection (Carmel &amp; Goldberg, 2022).</p> <p>To prevent urinary output over filling pouch and disrupting sleep (Carmel &amp; Scardillo, 2022).</p> <p>To prevent damage to stoma, hernia, and prolapse.</p> <p>The patient must be able to perform self-care before being discharged from hospital (Goldberg &amp; Mahoney, 2022).</p>
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<p>Incontinence-associated dermatitis (IAD) 2/2 fecal incontinence (FI), obesity, limited mobility post-surgery.</p> <p>BMI 38.1, indicating severe obesity class II.</p> <p>perineal/perianal slightly red blanchable without satellite lesions.</p> <p>The patient stated “I feels like I am leaking stool.”</p>	<p>Once you are cleared by the surgeon you may resume sexual relationship. Never use stoma with coitus.</p> <p>Learn the sign and symptoms: Urinary tract infection (UTI)/Kidney, cloudy urine, dark or bloody urine, foul odor, chills, increased mucus, fever, back pain, abdominal pain, nausea, vomiting, or diarrhea. Feeling tired, sleeping to much or not able to sleep, restlessness. If noticing any of these signs and symptoms contact the provider.</p> <p>Review Alkaline urine signs and symptoms will have Crystal formation on the stoma or peristomal skin can cause UTI or urinary calculi, notify the provider.</p> <p>Contact the WOC RN if the pouching system needs changing before Wednesday. Also, if see any irritation, rashes, erosions, adhesive burn. May need to consider convexity product.</p> <p>Identify possible causes of fecal incontinence.</p> <p>Use soft cloths and/or peri bottle for cleansing.</p> <p>PeriFresh no rinse perineal cleanser spray peri bottle mild</p>	<p>back correctly the pouching system change, cleansing, when to empty pouch, emptying pouch, complication signs and symptoms and when to contact the provider and WOC nurse.</p> <p>The patient feels stool leaking but would not like to try the bedside commode at this time. Prefer to use wipes, barrier ointment, and check herself more frequently before BSC.</p> <p>Patient verbalized understating.</p> <p>The patient has episodes of fecal</p>	<p>Many causes of diarrhea are an infectious or inflammatory process such as C-difficile, exacerbation of inflammatory bowel diseases, medications, and heavy sedation, along with other causes like nutritional deficiencies, enteral feedings, and gluten sensitivity with possibly leading to fecal incontinence (Callan &amp; Francis, 2022).</p>
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<p>“I will try the wipes and barrier first and check myself more frequently.”</p>	<p>Cleanse the skin using no-rinse incontinence cleaner Medline Remedy Essentials use with each incontinence episode.</p> <p>Apply barrier skin cream like Calmoseptine, apply to the perineal/perianal after each incontinence episode. Not necessary to remove all the cream, only clean soiled cream. Use mineral oil to remove the cream if necessary. If using external fecal collator device avoid rubbing zinc based cream near device.</p> <p>Use of bedside commodes (BSC) size appropriately. Use of correct positioning for bowel movements once the patient is willing to use BSC feet flat on, sitting upright with apart.</p> <p>Bariatric pressure redistribution mattress Protekt 600 bariatric pressure redistribution foam mattress</p> <p>Turn and reposition every 2 hrs. Avoid lying on back will increase damage to coccyx area.</p> <p>Keep 3 or less layers of linen on bed like sheet, pull sheet, absorbent pad.</p> <p>If skin damage increases will apply the external fecal pouch Convatec flexi-seal fecal collector with odor filter and attach a drainage bag Bardia anti-reflux valve urinary drain bag.</p> <p>List of foods to thicken up stool when you are cleared to eat. Foods high in</p>	<p>incontinence.</p>	<p>Some with a urostomy may complain of diarrhea (Carmel &amp; Scardillo, 2022).</p> <p>Obese individual has a greater rate of fecal incontinence (Gallagher, 2022).</p> <p>To promote normal stool, the fiber supplement will pull water from liquid stools to create soft-formed stools (Thompson, 2022). Restoring stool consistency one focus of management (Callan &amp; Francis, 2022).</p> <p>Moisture barrier care promotes skin repair and prevents further skin damage (Hull, 2022). Skin management is also a focus in fecal incontinence management (Callan &amp; Francis, 2022).</p> <p>Using a BSC provides quick access for elimination, to promotes continence (Kent &amp; Holderbaum, 2022). Bariatric size commond to accommodate obese patient.</p> <p>Provides maximum support, reducing friction, shearing, and comfort. Also keeps the patient cool and dry. Obese people with inconvenience need additional measures besides cleansing, moisturizing, and containment products (Gallagher, 2022).</p> <p>A non-invasive collection device for stool, which attaches externally, changes every 1 to 2 days, is designed to contain feces and protect the skin, can connect to a gravity drainage system, and track stool volume (Callan &amp; Francis, 2022).</p> <p>Monitoring the wound and periwound for infections (Colwell &amp; Hudson, 2022).</p>
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<p>Alter skin integrity 2/2 recent abdominal surgery, fecal incontinence, obesity.</p> <p>Midline abdominal incision, intact island dressing with a minimum strike-through serosang drainage. Incision measures 15cm x 1cm x 0.25cm. Periwound without induration, redness, or irritation.</p> <p>JP drain in RLQ with serosanguineous drainage</p>	<p>soluble fibers. Give bulking fiber supplement Citrucel Power orally daily, as per order once able to digest and cleared by surgeon to eat.</p> <p>Midline dressing removed.</p> <p>Notify the provider of redness on the periwound, presence of odor, or increased discharge from incision.</p> <p>Incision cleansed with normal saline, gently dry.</p> <p>Apply hydrogel impregnated gauze dressing to wound bed. Cover incision with an ABD pad dressing and secured with silicone tape.</p> <p>Alternative dressing: Systagenix wound management Adaptic non-adhering dressing to the abdominal incision cover with a transparent dressing, change every 2 days and as needed. Monitor for signs of infection call surgeon if see redness, swelling, increase drainage,</p> <p>Abdominal drain insertion site skin intact, without redness, track amount of drainage. Notify the provider with drainage leakage, redness, or irritation</p>	<p>Verbalize desire to not have this time.</p> <p>Surgeon at bedside during dressing change</p>	<p>Soaks up water from stool, thickens stool, decreases bowel transit time and digestion, also have a lubricating effect on the intestinal mucosa (Callan &amp; Francis, 2022).</p> <p>To relieve pressure and prevent skin damage. A patient having multiple layers of bedding under increased the risk for pressure injuries, as well as diarrhea, obesity and immobility (Gallagher, 2022 and Thayer &amp; Nix, 2022).</p> <p>A function of the postoperative assessment, monitoring abdominal drain (Colwell &amp; Hudson, 2022a).</p> <p>The patient should know signs and symptoms of complications keep patient informed and actively involve with care promoting self-care. Wound infection is diagnosed by clinical presentation (Stotts &amp; Schultz, 2020).</p> <p>The main goal for a postoperative dressing is to provide coverage to prevent environmental elements invading the wound, absorb drainage and provide an moist healing atmosphere (Brindle &amp; Creehan, 2022). Experts suggest a sterile occlusive dressing should be used until re-epithelialization occurs (Brindle &amp; Creehan, 2022).</p>
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<p>Alter comfort r/t recent surgery, bladder cancer, IAD.</p> <p>The patient reports abdomen is tendered.</p>	<p>at insertion site.</p> <p>Abdomen splinting hold pillow against the abdomen with moving, repositioning, coughing, or laughing any movement that may cause pressure on the abdomen or incision. Considering abdominal binder for support to abdomen.</p> <p>Take gabapentin one hour before the pouching system changes as needed as per order.</p> <p>Use alternate pain management techniques such as deep breathing, distraction, meditation, timeout, and visual imagery during pain episodes like pouch system change. Time out: patient stop the pain rich activity and take a timeout. Deep breathing: when pain starts taking slow deep breathing. Use visual imagery: think of an image(s) or location you enjoy. Meditation: use slow rhythmic breathing, clearing your mind and relaxing. Distraction is something that takes your mind away from the pain. These techniques can be used together or alone.</p> <p>WOC Services will follow up daily and continue to provide ostomy, wound, and continence support until discharge.</p>	<p>Patient verbalized understanding.</p> <p>The patient verbalized understanding. Patient utilizing pillow for abdominal splinting sitting up in bed.</p> <p>The patient verbalized understanding, no pain at this time.</p> <p>The patient verbalized understanding and appreciation for the help.</p>	<p>To support, immobilize, and control pain at the abdominal incision and help with healing.</p> <p>Pain constricts blood vessels inhibiting healing. Alternative measures to control pain. Distraction technique to get mind off pain/and discomfort (Woo &amp; Sibbald, 2020).</p> <p>The patient should know when to expect WOC nurse visit during hospitalization for support and decrease anxiety dealing with new ostomy. The WOC RN will continue to</p>
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			educate, prevent further skin trauma, promote healing. The WOC nurse is vital to restoring patient's quality of life (Carmel & Goldberg, 2022).
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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
<p>Discharge planning</p> <p>Support for wound, ostomy, and incontinence care.</p>	<p>Follow-up in clinic with WOC service 2 weeks after discharge and annually, or sooner if continuous leakage or skin irritation. Annual monitoring of vitamin B12 usually takes two to five years to detect.</p> <p>Review support resource available for information, local support groups clothing retailers, supplies and suppliers are at UOAA website at <a href="http://www.uoaa.org">http://www.uoaa.org</a>.</p> <p>Consult social work for insurance coverage on ostomy supplies.</p> <p>Consult psychology for signs and symptoms of depression or anxiety.</p> <p>Referral to home care or subacute rehab facility.</p> <p>Obtain bariatric and pressure redistributing supplies, bed, mattress, chair, chair cushion, commode, bedpans, and scale.</p>	<p>The patient has a urostomy, incisional wound, and incontinence-associated dermatitis from fecal incontinence.</p>	<p>To provide Wound, Ostomy, and Continence care, education, provide answers to patient's questions and follow up to correct appliance fit and prevent complications (Carmel &amp; Goldberg, 2022). (Carmel &amp; Goldberg, 2022). To avoid Vitamin B12 deficiency (Carmel &amp; Scardillo, 2022).</p> <p>Provide resources for information, knowledge is power, discuss insurance coverage and cost of ostomy supplies and additional consultation as needed (Carmel &amp; Goldberg, 2022).</p> <p>Depending on patient's needs at discharge but assist will be needed once patient leave hospital (Carmel &amp; Scardillo, 2022).</p> <p>Healthcare needs to provide appropriate care and equipment to all, regardless of size. Some facilities lack adequate supplies and equipment for oversize people (Gallagher, 2022). Many obese people have a fear of breaking equipment, embarrassed to ask questions (Gallagher, 2022).</p>

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