WOC Complex Plan of Care

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Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
Pt is a 43 female with a past medical history of paraplegia, spina bifida, anemia, osteomyelitis chronic bladder, and bowel incontinence. Pt had medulloblastoma at 5 years old and was treated successfully with surgery and radiation. Pt has a suprapubic catheter and colostomy. Admitted with a stage #4 pressure injury. Pt is chronically wheelchair bound; however, she still retains fair functional capacity, can wheel herself around and pivot from bed to chair. Additionally, she can turn in bed with assistance. She has Medicaid as her insurance. She lives at a skilled nursing facility. Pt is an experienced ostomate, has supportive parents and will be d/c to SNF. Pt admitted due to nausea, vomiting, and dehydration. Pt stated on admission that she had decreased ostomy output for two days. Pt was placed on a NPO diet and had an NG tube for three days. Pt successfully passed NG clamp trail and started on a clear liquid diet. Tolerating diet well. Pain is well controlled, pt states she is feeling better but is starving. Colostomy output with 75 cc of thin liquid effluent documented. SP catheter has clear urine as seen in drainage bag; peri drain skin intact. Physical therapy consulted. Plastic consulted for possible debridement of pressure injury. **Medications** **Tylenol, Zofran, Fluoxetine, Ferrous sulfate, Lovenox, insulin glargine, Lipitor**	**Labs from current day** **A1c 7.5%** **HGB 11.0** **HCT 34.5** **Plts 248** **WBC 13.15** **Glucose 250** **BMI 26** **Kub showed no dilated gas filled colon or small bowel**

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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Altered wound healing due to uncontrolled diabetes and increased BMI.	Endocrine, diabetes specialist, nutrition consultants for diet education, medications, and for optimized wound healing.	Pt can make appropriate dietary choices which includes eating fruits, vegetables, protein, and whole grains. Pt will be able to verbalize which food or beverages contain sugar. BMI is between 18.5 and 24.9	Endocrine, diabetes specialist and nutrition are trained specifically in how to help a patient with diabetes. They play a crucial role in developing a personalized treatment plan. Understanding which food is appropriate will help make the pt pick appropriate food choices. Consequently, the pt's diabetes will be better controlled, leading to weight loss, and increased wound healing ability.
	Check A1C every three months.	A1C 7% or less	AIC measures the blood sugar average blood sugar of the last 3 months and can help determine if a pt's blood sugar is improving (Elsevier, 2023).
		ACHS (blood sugar checks before meals and at bedtime)	To determine if the pt's is getting the correct dose of insulin/medication. If the blood sugar is still too high, pt might need an increase in medication. Hyperglycemia causes the narrowing of blood vessels which can

Chronic Anemia	Oral iron 325 Mg to be taken every other day. (Per MD order)	Monitor weekly CBC Monitor for signs and symptoms of Anemia. Example, fatigue and having a headache	contribute to a pressure injury, and delay wound healing. It decreases the ability of leukocytes to reduce bacteria in the wound bed (Nasiri et al., 2021). People with anemia have reduced oxygen delivered to the wound bed, which can decrease wound healing ability (Tuz & Mitchell, 2021). These symptoms can indicate the medication is not working and the pt requires a higher dose of medication.
Braden Scale Sensory 2 Moisture 2 Activity 2 Mobility 2 Nutrition 2 Friction and shear 1 SCORE 11 **High risk for further pressure injuries**	Skin inspection twice daily. Keep skin clean and clean up any incontinence episodes immediately. Protect skin from moisture. Turn and position the pt every two hours when the pt is in bed. Place Allevyn Gentle Border Dressing over bony parts of the body (heels, elbows, hips) change dressing every 3 days or earlier if soiled.	No new pressure or MASD is created. Documentation that the pt is being and turned and the position pt was turned .	When skin becomes wet it is susceptible to breakdown and cause MASD. Cleaning any episode of incontinence immediately will reduce any skin breakdown (Thayer, & Nix, 2022). Turning every two hours will help prevent pressure injuries. Repositioning will relieve pressure and improve blood circulation, decreasing the chance of developing a pressure injury (R.B. Turnbull, Jr. MD School of WOC Nursing Education, 2022).

	The alternative product is Mepilex.		Bony prominences are more susceptible for pressure injuries, covering with an Alleyn with help off load pressure reducing the chance of a pressure injury (R.B. Turnbull, Jr. MD School of WOC Nursing Education, 2022).

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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
	When the pt is in a wheelchair, she should sit on the seat cushion (Ergonomic Pressure Relief Seat Cushion, it is designed to relieve pressure while sitting. Alternative product EHOB Waffle Seat Cushion this is a cheaper option). Use the foam wedge, Medline Comfort Glide Foam to offload patient's coccyx**.** Alternative product would be a pillow.	No new pressure or MASD is created. Pt is seen using a seat cushion when sitting in a chair or wheelchair.	Ergonomic Pressure Relief Seat Cushion is designed to relieve pressure from the tailbone, hip and thigh area (Ergonomic pressure relief seat cushion," n.d.) Cushions distribute pressure evenly, reducing the risk for a pressure injury. Foam wedges are easy to use and help maintain proper body alignment.

	Pt should wear Tru-Vue heel protector boots to bilateral lower extremities. Another option to use is to place pillows under calves to offload heels while in bed.	Documentation in nurses' notes pt is wearing Tru-Vue heel protector boots, Skin integrity maintained., feet should be examined once a shift.	Tru-Vue heel protector boots protect feet from injury because they provide cushioning and redistributes pressure . Offloading the feet will help prevent pressure injury (Edsberg, 2022).
	Educate pt on the plan of care, using therapeutic communication. Ask the patient if there are any questions regarding pressure injury prevention plan. Evaluate if the patient is declining any care and adjust accordingly. For example, if it's too difficult for the patient to turn every two at night, increase the intervals to every four at night so the patient can sleep.	Use the teach back method in order to make sure the patient understands what the necessary steps are to prevent further pressure injuries. Patient is happy and compliant with her pressure injury prevention plan.	For pressure injury prevention/care to be effective, the patient needs to understand ,and be compliant in care. Educating a pt is key to success in the plan of care (Aremu et al., 2022).
	Emphasize to pt to report any new sign of a pressure injury. Use of a low air loss mattress .Alternative product is a dolphin bed.	Skin integrity maintained.	Early intervention can help minimize the pressure injury and lead to prompt interventions. The mattress is designed that it reduces heat and moisture build up, thus decreasing the chance of a pressure injury (Help Mobility, n.d.)

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Stage #4 pressure injury to sacrum Pt has a stage #4 pressure injury on her sacrum, the wound base is red with areas of light layer of yellow, peri wound is blanchable erythema. The shape is an irregular wound measuring 6.6 cm x 3.4 cm x 3 cm with scant serosanguinous drainage, no odor.	**Daily wound care:** Clean the wound with normal saline, gently dry, gently fill the wound with Vashe soaked Kerlix, cover with ABD, secure with tape. Change daily and as needed (change if it becomes soiled) Alternative product; using NPWT with vera flow. It improves blood circulation, drains exudate and helps facilitate granulation Take pictures and measurements weekly. Document if any sign of infection, granulation tissue and output	Wound shows signs of improvement: Reduction in exudate, increases granulation tissue, decreases in size.	Vashe can be used for wound debridement and removal of bacteria. It is intended to be used for pressure injuries (Urgomedical, n.d.) Wounds that have depth need a dressing that will fill in the depth (Jaszarowski, & Murphree, 2022). Record measurement, pictures and changes in the wound will help clinician evaluate if the wound is healing correctly.
Pain related to wound care.	Evaluate if pain medication is needed prior to wound care . Use the verbal pain scale (1-10) . Reassess the pt's pain levels after 30 minutes. Play classical music, if the pt is agreeable while doing wound care.	Pt states pain is less than 3 after wound care. Using the Hamilton Anxiety Scale, Pt reports reduced anxiety during dressing care scoring Pt report a score of 16 ..	When a person is in pain it can lead to immune system dysfunction due to cytokine production and increased inflammation. Consequently, the pain a pt experience can cause stress which releases cortisol, that can negatively affect the immune system because it is decreasing the immune system's ability to fight infection (R.B. Turnbull, Jr. MD School of WOC Nursing Education, 2022). The Hamilton Anxiety Scale can help clinicians determine a pt's anxiety, and if interventions are working (Baker et al., 2019).

			Playing classical music during wound care dressing has been shown to reduce anxiety and blood pressure (Cheng et al., 2021).
Peristomal Care **Stoma type** Loop descending colostomy Diameter 1" changes with peristalsis Located LUQ Protrusion budded. Mucosal intact Peristomal skin Erythema and denuded circumferentially. Peristomal abdomen flat. Supportive tissue firm Character output liquid brown effluent **The flange was bigging cut too big which led to the peristomal skin complication.** **Current pouch system** **Hollister New Image 2 ¼ Flat Flex wear cut to fit, drainable pouch**	Pt's abdomen is firm, and stoma is budded, Hollister New images flat flex wear is appropriate for stoma. However, the flange was cut too big. **Pouching instruction** Use adhesive remove and remove pouch with push pull technique. Clean skin with warm water and gently pat dry. Apply stoma powder circumferentially around stoma. Dust away excess powder. Apply 3m skin prep. Apply Hollister Skin barrier/ Hollihesive triangular shape washer. **How to make a Hollihesive triangular shape washer** Trace template, using a marker ,and cut out Hollihesive ,	Change pouch in 3 days, and assess peristomal skin, if the skin is improving, that would indicate that the precut flanges are working. Pt able to create and apply Hollihesive triangular. Pouch last 3-4 days with no leaking Pt was given WOC contact information to call if her peristomal skin is not improving or she is not getting a good seal.	Chronic leaking of stool or urine leads to irritant dermatitis. Having a good seal will help the peristomal skin heal (Salvadalena, & Hanchett, 2022). Pt was cutting her flange too big which led to irritation and leakage. Education is important, so she understands what causes peristomal skin complications. Stoma powder absorbs moisture and lets the pouch stick better. Too much powder does not allow the pouch to stick well. 3M skin prep will seal the powder, it helps protect the skin from irritation caused by urine and/or fecal incontinence (Salvadalena, & Hanchett, 2022).

Pouching system placed in after assessment Hollihesive washer, Hollister New images flat flex wear, Precut flange 1 ¼" ,drainable pouch.	the smooth side goes on the skin, the pattern side stick up. Educated pt how to create a Hollihesive triangular, and how to apply. Template created for pt to copy. Pt is an experienced ostomate who already knows how to apply a pouch). Appy,precut flange, and drainable. Pt was given prescription and supplies for Hollister New images flat flex wear, Precut flange 1 ¼", so that it will be easier for her to apply the pouch system. Having a precut option will make pouching easier for the pt and reduce the chance she will cut the flange too big. Alternative option would be Coloplast SenSura Mio Flex Flat drainable pouch, with a precut to 1 ¼" flange. Hollihesive washer used to protect the peristomal skin. Alternative product is Coloplast Brava Skin Barrier Protective Sheets. Designed to protect the peristomal skin from urine and/or	Skin is clean and intact.	Hollister Hollihesive absorbs moisture and provides an extra layer of protection .

	fecal incontinence.	No new episodes of emesis. Pt consuming 50-75% of meals.	
Lack of knowledge on diet and dehydration prevention	Change the pouch immediately if there is a leak.	Pt is maintaining a healthy weight.	Too much ostomy output can indicate dehydration. Having little to no ostomy output can indicate a blockage.
		Pt reported what liquids are appropriate for a clear liquid diet.	
	Educated the pt on signs of dehydration.	Pt given Cleveland Clinic 2 weeks I/O paper that she can fill in her output.	It is important that the pt understands her diet to prevent any blockage.
	Educated the pt on a clear liquid diet. Record how much food is being consumed with every meal.		Keeping track, I/O will help the pt if she needs to call her MD.
	Educated the pt on recording ostomy outputs.		
Suprapubic catheter Assessment Located below the umbilicus. Peri drains site clean, dry and intact Peri tube contour flat Dressing Medline nonwoven Drain Sponges, Connected to gravity drainage, clear yellow drainage.	Daily care and PRN Examine catheter insertion site daily for any erythema , discharge or swelling. Wash hands before and after SPT Care. Clean site daily as needed. Wash with warm water and gently dry. Apply 3m skin prep and stoma powder PRN for skin irritation) Dust off excess powder	Peri drains site should have no signs of skin irritation, exudate or swelling.	To prevent infection, it is important that proper hygiene precautions be taken when caring for Subpubic catheter (Cleveland Clinic, n.d.).

	Alternative product Safe n' Simple No Sting Skin Prep Wipes, Unscented & Alcohol Free Skin Barrier Wipes, Place a sponge drain and secure with tape. Dressing Medline nonwoven Drain Sponges Alternative product Kendall Dermacea Non-Woven Drain Sponge Ensure the tube is secure and without any kinking. Secure the tube with an Easecare foley security device. Alternative product Hollister drain holder. Gravity drainage bag should be placed below the bladder and avoid kinking of the tube. Empty drainage bag when 1/3-2/3 full. **Home care instructions for**	Tube remains in place with no kinking, urine is draining. Daily assessment that the drainage bag is placed correctly. Pt should have no pain ,with leaking at tube insertion site and be free of any symptoms of infection.	To minimize the risk of dislodgement or kinking of the tube. The tube must be secured. (R.B. Turnbull, Jr. MD School of WOC Nursing Education, 2022). Correct position will reduce the risk of complications, such as urine not draining correctly (R.B. Turnbull, Jr. MD School of WOC Nursing Education, 2022). . Early detection of problems will enable healthcare providers to put interventions into place.

	gravity drainage bag Clean bag daily with soap and water. Another option is to use 1 part vinegar and 3 parts waters. Change bag every 5-7 days.	No odor coming from gravity drainage bag.	To retain hygiene, prevent infection, and decrease odor (Cleveland Clinic, n.d.).
	Drink fluids as instructed by MD	Pt is hydrated and has no signs of a UTI. Pt able to tolerate the recommended amount of liquid recommend by MD	Proper hydration prevents urine from being concentrated, decreasing the chance of a UTI (Alberta, n.d.).

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