WOC Complex Plan of Care

Name: Sara Bickford **Date: 8/14/23**

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
38-year-old male with a history of a failed suicide attempt from jumping off a bridge 7 years ago, resulting in TBI, spinal cord injury, and quadriplegia. Pt had G tube placement following the accident with continuous feeds with a pump. Pt is dependent on all care. Pt is minimally verbal due to TBI and requires frequent repositioning and hoyer lift for transfers. Pt had been without any skin issues for almost one year and had just recently developed a pressure injury to the lower coccyx due to a malfunctioning low air loss mattress. WOC nurse evaluation today to determine if NPWT is appropriate wound treatment for pressure injury. Negative pressure wound therapy had been placed on the wound about one week ago by PCP. During the visit today, the dressing was removed, and the wound was cleaned. The wound appears to be 100% adherent slough with scant drainage in NPWT canister. The wound measured 2.2cm in length, 3cm in width, and 1.8cm in depth with slight undermining from 12 o clock to 3 o clock. Due to adherent slough and minimal drainage, the NPWT wound not be appropriate at this time. Caregiver stated that she had used hydrofera blue dressing on him with his past pressure injury over a year ago, which did help heal his wound. Call made to PCP while in the home to inform of wound status. The order changed to hydrofera blue dressing, covered with DSD and secured with medipore tape, changed every 2-3 days. Caregiver educated on how to perform wound care as well as what to report for signs of infection. The plan is to pause the NPWT for one week to monitor wound healing and reduction of slough while using the hydrofera blue dressing. Nurse did find on the assessment of the low air loss mattress, that there was a small leak and the mattress had not been functioning correctly to provide support. PCP did place an order for a new mattress, and a mattress cover was placed over the mattress in the meantime while waiting for the mattress to arrive.	**NOT ABLE TO ACCESS CURRENT LAB WORK RESULTS DUE TO HOME CARE SETTING**

WOC Complex Plan of Care

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
1. Delayed wound healing related to limited mobility/ paraplegia. (Wound) -38 year old male Braden: Sensory Perception: 2 Very limited Moisture: 2 Often moist Activity: 2 Chairfast Mobility: 2 Very limited Nutrition: 2 Probably inadequate Friction and shear: 1 Problem Score: 11 (High risk)	1. – Wound assessment at every nursing visit and document findings. Report signs of infection, including increased erythema, odor, fever, drainage, and pain. -Pause NPWT until the reduction of slough in the wound bed. -Clean the wound with saline, apply hydrofera blue (Methylene blue and gentian violet) to the wound bed, cover it with DSD, and secure it with medipore tape. The Home health nurse changes dressing every 2-3 days and teaches the caregiver how to perform. Alternate dressing if supplies are unavailable: Calcium alginate dressing with silver may also be a good option if hydrofera blue is unavailable. This would still provide a moist healing environment, provide antimicrobial properties, and absorb exudate. -PCP to order new low air loss mattress through black bear medical supplies based of current BMI of 28. PCP advised PCG to place a foam mattress pad on top of the	1. -PCG is able to verbalize current wound care orders as well as verbalizes understanding of upcoming plan with revaluation of the wound vac once slough is removed. - Notes recently state that patients wound was 100% beefy red after 2 weeks of using the hydrofera blue dressing. NPWT was then resumed for treatment per provider. - New low air loss mattress was delivered to patient and patient was switched to functioning mattress. Pressure relief measures and repositioning still needed at least Q2 as well as floating of heals. - No further skin issues noted, no IAD noted. Skin integrity maintained surrounding wound.	1. -This wound care will provide an antimicrobial moist environment for wound healing. -Methylene blue and gentian violet has been shown to provide antibacterial properties to the wound to help prevent infection (Weir & Schultz, 2022). -The use of a low air loss mattress will aid in pressure relief and is specific to one's body weight so that the air can be distributed evenly -Roho cushions for the wheelchair provide pressure relief by adjusting to the patients buttock, these cushions are also safe and recommend for patients with a current pressure injury.

	current mattress until a new air mattress arrives. -Q1 hour repositioning while awake until he gets a new mattress. Can change to Q2 once on functioning low-air mattress. -Use of foam dressing (mepliex) to pressure point areas to provide protection. -Offloading heals at all times while in bed. Can use pillows under calves to raise feet from bed and elevate HOB to about 30 degrees to prevent shear/friction from sliding down. -Skin care provided 2x day and after every fecal incontinence episode. PCG to apply barrier cream to protect intact skin surrounding wound. PCG to also change dressing if it becomes saturated or soiled. -Use of Roho supportive pressure releiving cushion in wheelchair when out of bed. (alternative to a Roho cushion may be a gel or foam cushion, but the would not provide as much support)		

2. Malnutrition due to gastrostomy tube feedings. (Ostomy) -BMI- 28	2. - Continue with G tube feeding using Nutrin tube feed with a kangaroo pump per nutritionist recommendations. The patient is also to eat PO soft foods PRN throughout the day. -Monitor for complications with G tube including displacement. -Assess gastrostomy insertion site for signs of hyper granulation or infection. PCG to report signs if infection including redness around site, drainage around site, fever, pain. -Stabilize tube at all times with stabilizer and avoid kinks in tubing. -Alternative for a G tube stabilization device could be a foley catheter stabilizing device. Both will keep tube in place and help prevent migration and dislodgement of tube. -Keep HOB at least 30 degrees while continuous tube feed is on to prevent aspiration.	2. -PCG verbalizes and demonstrates an understanding of G tube care as well as appropriate management of feedings following recommendations from a nutritionist. -Notes recently state that patient is continuing to get nutrients through tube feeding with no changes in formula or rate. Pt also continued to eat some foods PO throughout the day. -Pt maintains no issues with gastrostomy site.	2. -Supplemental nutrition is needed for this patient to maintain the appropriate nutrients. Following a TBI, the body needs certain nutrients in the diet to aid in recovery from the neurologic injury (Mark et al., 2022). - Stabilizing the tube at all times will help prevent dislodgement of the tube and prevent complications. - Maintaining the HOB at 30 degrees or higher will reduce the risk for aspiration

3. Recurring UTI due to chronic indwelling foley catheter. (Continence)	3. -Change foley catheter using 16F with 10ml balloon catheter one a month and document the date changed in patients chart. (alternative for this catheter if a 16F was not available, may be a 14F or 18F if approved by urology. A coude catheter may also be needed if this patient has an enlarged prostate). -Educate caregiver on foley catheter care and hygiene. Including cleaning the tube with alcohol once a day, keeping drainage bag below bladder level, and cleaning around penis with soap and water daily. -Assess for signs of UTI at every nursing visit and teach caregiver to report any signs of infection such as fever, increased odor to urine, sediment/cloudy urine, and pain.	3. -PCG verbalizing interventions to aid in infection prevention and proper catheter care such as proper hygiene, maintaining drainage bag below bladder level, and changing bag/tubing with necessary. -Notes show that patient recently had suprapubic catheter placed by urology to aid in comfort with his long term catheter. Pt maintains no complications or infection following new suprapubic catheter placement.	3. – Infection may stall wound healing and potentially lead to sepsis and death. - Maintaining a catheter with no complications will aid in wound healing and decrease risk for hospitalization. -Although a suprapubic catheter and a transurethral catheter may not differ in the amount of UTIs one may develop, it has been shown to aid in comfort and convivence to some patients (Kranz et al., 2020).

References:

Kranz, J., Schmidt, S., Wagenlehner, F., & Schneidewind, L. (2020). Catheter-Associated Urinary Tract Infections in Adult Patients. *Deutsches Arzteblatt international*, *117*(6), 83–88. https://doi.org/10.3238/arztebl.2020.0083

Mark, I., Hey, G., Colliander, R., McCracken, B., Casauay, J., & Lucke-Wold, B. (2022). The Role of G-tube Placement for Neurologic Injury Patients. *Biomedical science and clinical research*, *1*(1), 1–10.

Weir, D. & Schultz, G. (2022). Assessment and management of wound-related infections. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management (2nd ed., pp. 187-213). Wolters Kluwer.