WOC Complex Plan of Care

Name: _____Michele Ramirez_____ Date: ____2/29/2024_____

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
G.C is a 52-year-old female with history of Type 2 DM, sleep apnea, Bipolar disorder, HLD and chronic diverticulitis. Patient noted development of right groin abscess which has been worsening x 1 week. She presented to Lutheran ED, providers attempted to drain abscess, however patient could not tolerate full procedure so only part was drained, no packing placed. She states that three hours after her I&D at Lutheran she suddenly became acutely ill with malaise and vomiting. She had vomited seven times since her I&D. She had been feeling fever, chills, nausea and headache. She was prescribed Bactrim following her I&D but has been unable to take it due to vomiting. Patient reports extreme pain and tenderness to her right groin and adjacent right upper thigh. She continued to have increasing pain, so she presented to CCF ED for further management. CT obtained in ED noted myositis and fasciitis in proximal right gracilis muscle. Right inguinal cellulitis and adenopathy. Denies fever or chills. Pain has been improving since arrival to ED where she received aztreonam, clindamycin, and vancomycin. WOC nurse consulted regarding surgical wounds in the right groin and right upper thigh. Patient instructed on visit plan and agreeable. The patient is s/p debridement of skin and subcutaneous tissue, muscle, and fascia for necrotizing soft tissue infection on 01/26/2024. General surgery requested a WCCT consult for recommendations for the surgical wounds. There are Penrose drains in both wounds. No drainage was noted on the drains or on the absorbent pads under the patient. The packing removed from the wound on the right thigh was saturated with drainage after only being in place for four hours. Both wounds are full thickness with red and pink wound beds with some yellow adherent slough noted. The surrounding skin is edematous and erythematous. Right groin wound measures 1.2 x 3.5 x 1.5 cm. Right upper thigh wound measures 2.5 x 1.5 x 4 cm. The patient endorses 7/10 pain at the sites of the wound during dressing changes. Cleanse wounds with wound cleanser and pat dry. Cut Hydrofera Blue foam dressing to fit wound. Moisten with normal saline and	**February 2, 2024** CBC with leukocytosis 12.31 Glu 326 BHB elevated 3.45 Hyponatremia 132 Hypokalemia 3.5 Bicarb 19 Cr 0.73VBG with an elevated lactate 2.2 ALT 17 AST 15 CK 45 A1c 13 Braden Scale 17: Mild risk CT Femur: right proximal gracilis myositis and fasciitis. Right inguinal and right proximal thigh cellulitis with associated adenopathy

wring out excess. Place Hydrofera Blue in wound and cover with a dry sterile dressing. History of diverticulitis who underwent a colostomy procedure in 2021. Abdomen noted to be soft and tender to palpation. Colostomy in LLQ. Appliance system removed. Stoma intact, pink, and viable. No signs of irritation or infection noted. Patient tolerating a regular diet without any issues and has been emptying the ostomy pouch 2 – 3 times a day independently without any significant concerns or discomfort. Semi-formed brown colored stool output, noting a moderate amount with a mild odor. No signs of abnormalities or distress related to the colostomy output identified. Ostomy opening measures 1 ¼" (32 mm). Cleansed with warm water and mild soap. Pat dry. Hollister New Image two-piece drainable pouch with flexible barrier applied. Additional supplies left at bedside. Patient reported experiencing occasional episodes of urinary leakage over the past few days, which she contributes to increased fluid intake and decreased mobility due to her hospitalization. Denies any pain or discomfort with urination and reposts no history of UTIs. Patient's urine is clear and without any unusual odor. Patient medication regimen has been reviewed and there are no medications that are known to cause or worsen urinary incontinence. Mild blanchable redness noted to perineal area. Perineal area cleansed using soft cloth. Skin barrier ointment applied and left in room for use PRN. Establishing a scheduled toileting routine based on a patient's usual bowel and bladder habits. Additionally, aiding with mobility using assistive devices like a walker can help patients access the bedside commode promptly when needed. PT consult to be placed. Patient informed that transient incontinence could happen as a result of hospitalization, but that it is often temporary and can improve with time. Provided education on incontinence management techniques, such as pelvic floor exercises or bladder training, can also be helpful in improving symptoms and promoting a faster recovery. Verbalized understanding. Agreeable to plan of care. Current medications: Ondansetron 4 mg injection IV q 6 hr PRN Melatonin 3 mg tab daily PRN Lovenox 40 mg subcutaneous q 24 h Acetaminophen 1,000 mg oral q 8 h Glargine 20 units subcutaneous at bedtime Admelog subcutaneous with meals	

Ceftriaxone 2 g in D5W 100 mL vial bag Intravenous q 24 h Metronidazole 500 mg oral q 8 h Morphine 2 mg injection intravenous q 12 h PRN Oxycodone ER 10mg oral q 12 h Oxycodone IR 5mg oral q 6 h PRN WOC Recommendations: **Colostomy**: Cleanse with warm water and mild soap. Pat dry. Hollister New Image two-piece drainable pouch with flexible barrier **Perineal care**: skin barrier ointment **Surgical wound right groin**: cleanse wound with wound cleanser and pat dry. Cut Hydrofera Blue foam dressing to fit wound. Moisten with normal saline and wring out excess. Place Hydrofera Blue in wound and cover with a dry sterile dressing. **Surgical wound right upper thigh**: cleanse wound with wound cleanser and pat dry. Cut Hydrofera Blue foam dressing to fit wound. Moisten with normal saline and wring out excess. Place Hydrofera Blue in wound and cover with a dry sterile dressing. Prevention: Off-load heels while in bed Nutrition consult advised for optimized wound healing PT consult Continue skin prevention interventions based on Braden risk assessment subset scores WCCT will continue to follow patient. Please reconsult if wounds worsen.	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale

WOC Complex Plan of Care

COLOSTOMY - LLQ colostomy - Stoma intact, pink, viable - Semi-formed brown colored stool output - Moderate amount output - Mild odor - Stoma measures 1 ¼” (32 mm) - Peristomal skin intact and without irritation	**Stoma Care** - Remove pouching system carefully so as not to pull on patients skin. - Cleanse with warm water and mild soap. - Pat dry. - Continue using Hollister New Image two-piece drainable pouch with flexible barrier. Depending upon how often the stoma functions, an individual will use either a drainable pouch or closed-end pouch (Stricker, et al., 2022). An alternative: Coloplast Sensura Mio two-piece drainable pouch. Patient independently empties pouch - Instructed to sit on toilet and find comfortable position - Instructed to empty pouch when it is one-third full - Carefully open the bottom of the pouch by unfastening the closure. - Hold the bottom of the pouch over a toilet or a container, and then gently squeeze the contents out of the pouch. - You can use toilet paper or a soft cloth to wipe the inside of the pouch clean but be careful not to wipe too hard or you may damage the pouch. - Once the pouch is empty, you	- Patient is doing pouch system change independently. From removing the old one, cleansing the site, to replacing it with a new one. - Patient emptying pouch without help from nurse	- A gentle removal of the barrier by using a “push pull” technique from the top down helps to protect the peristomal skin from mechanical injury (Carmel & Goldberg, 2022). - Cleansing the area with warm water and mild soap helps to maintain skin integrity and prevent infection. Patting the area dry is important to avoid skin irritation and ensure adhesion of the new pouching system. - The recommendation to continue using the Hollister New Image two-piece drainable pouch with flexible barrier or an alternative, Coloplast Sensura Mio two-piece drainable pouch, is based on the patient's individual needs and preferences. - Sitting on the toilet can provide a stable and convenient location to empty the pouch. Finding a comfortable position helps the patient feel at ease and aids in effectively emptying the pouch. - Emptying the pouch when it is one-third full helps prevent leakage or overfilling, which can lead to discomfort and potential skin irritation around the stoma. - Wiping the inside of the pouch clean helps remove any residue and maintains hygiene. - Being gentle while cleaning the inside of the pouch minimizes the risk of causing abrasions, irritation,

	can securely close the bottom of the pouch by re-fastening the closure. - Wash your hands thoroughly before and after emptying the pouch to prevent the spread of bacteria. Preventing Complications - Educate/teach how to properly maintain and care for the pouching system. This includes following the manufacturer's instructions for changing the pouch, cleaning the skin around the stoma, and ensuring that the pouch is securely attached to the skin. - Monitor the skin around the stoma for any signs of irritation, redness, or inflammation. If you notice any changes, contact your healthcare provider/WOC nurse right away. - Staying hydrated: Avoid drinking beverages that can dehydrate you, such as alcohol and caffeinated beverages like coffee and tea. These drinks can increase urine output and cause dehydration. Recommended to drink at least eight glasses of water per day - Drink electrolyte-rich drinks, such as sports drinks or coconut water		or damage to the pouch, which can lead to discomfort or leakage. - Drinking adequate fluids is essential for overall health and maintaining proper hydration levels. - Avoiding dehydrating beverages like alcohol and caffeinated drinks helps prevent dehydration, which can lead to electrolyte imbalances and impact stoma output. - Drinking at least eight glasses of water per day supports hydration and helps regulate bowel function.

	Patient education - Reinforce teaching patient how to care for their stoma. Include cleaning, inspection for signs of infection/irritation, and proper techniques for changing the pouching system. - Educate the patient on skin care around the stoma, including prevention and management of skin irritation, and the importance of keeping the peristomal skin clean and dry. - Demonstrate how to empty and change the colostomy pouch, including proper hygiene practices and equipment for pouch changes.		
Urinary incontinence: transient incontinence. Transient UI is generally defines as newly occurring UI of relatively sudden onset: it typically lasts <6 months and is the result of reversible factors (Ermer-Seltun & Engberg, 2022). - Patient reports experiencing occasional episodes of urinary leakage during hospitalization	- Implement a toileting schedule that encourages regular voiding. To be successful in reducing the number of incontinent voids, staff must adhere to the schedule of timely toilet access (Palmer, 2022). - Provide education on pelvic floor exercises and other strategies to strengthen the muscles that control urination. - Reducing caffeine to decrease the frequency of incontinence episodes. - According to Mayo Clinic	- Evaluate the patient's adherence to the schedule and any improvements in their ability to void regularly. - Monitor the frequency and severity of incontinence episodes to determine if schedule is helping to reduce accidents. - Assess the patient's comfort level and satisfaction with the toileting schedule. - Measure the patient's engagement with pelvic floor exercises and their ability to perform them correctly. - Assess the patient's overall fluid intake and hydration status to	- A toileting schedule help establish regular voiding patterns, which can reduce the risk of accidents and improve bladder control. - Scheduled toileting promotes healthy habits and prevents the bladder from becoming overfull, which can lead to incontinence episodes. - Using assistive devices empowers patient to perform daily task and move around with greater confidence. - Walker provides stability and support. - A PT can work with the patient to

	Health System (n.d.), target total fluid intake to 40–60 ounces per day. Limit fluid intake after 6 p.m. to reduce night-time voiding and incontinence. - Help with mobility using assistive devices, such as walker, to help access bedside commode when needed. - Refer to PT Patient education - Educate patient that transient incontinence is temporary and can be caused by different factors. - Encouraged patient to practice pelvic floor exercises and limiting caffeine. - Reinforce that the right treatment and management, it can be effectively managed.	ensure adequate hydration despite reduced caffeine consumption. - Evaluation of these strategies may involve a combination of subjective feedback from the patient regarding symptom improvement, objective measures of incontinence episodes and any modifications needed to optimize the management of urinary incontinence. - Close monitoring and regular follow-up with the patient to assess effectiveness of the interventions.	develop a personalized exercise program aimed at strengthening the muscles that control urination and bowel movements. This might include exercises to strengthen the pelvic floor, as well as other exercises to improve overall muscle tone and coordination - Providing patient education and support can help patients navigate their incontinence with knowledge and well-informed decision making.

WOC Complex Plan of Care

Surgical wounds Right groin Right upper thigh	- Give prescribed pain medication 30 minutes prior to dressing changes. - Remove the old dressings gently - Cleanse with normal saline. Normal saline is an effective agent for wound cleansing when delivered with enough pressure to ensure adequate removal of surface debris (Weir & Schultz, 2022). - Pat the wound dry with sterile gauze pad - Cut Hydrofera Blue to fit wound. - Moisten with NS and wring out excess. When hydrated, the foam becomes a soft, comfortable wound filler and contact dressing (Weir & Schultz, 2022). - Place Hydrofera blue in wounds and cover with a dry sterile dressing - Change daily or as needed based on drainage	- Patient endorses 7/10 pain at the sites of the wound during dressing changes. - Patient is opiate naïve and tolerating Tylenol 1 g TID along with oxycodone 5 mg 0 6 h for breakthrough PRN. - Evaluate patient's pain level before and after administering the medication to assess its effectiveness. - Monitor for any changes in wound characteristics or signs of infection after cleansing wounds. - Evaluate overall wound appearance, exudate management, and healing progress with the use of Hydrofera Blue dressings. Compare the current wound appearance with previous assessments. - Monitor for any signs of infection, or other issues that may require adjustment of the dressing change frequently. - Reinforce wound care instructions and provide education on self-monitoring for signs of infection, dressing changes. - Document findings of all evaluations	- Removing old dressing gently helps prevent trauma to the wound site and surrounding skin. - NS is a safe and effective wound cleansing agent that helps remove debris, bacteria, and dead tissue - Patting wound dry with sterile gauze pad helps remove excess moisture, to prevent bacterial growth. - Hydrofera Blue dressing facilitates autolytic debridement, promote a moist wound environment and aid in the management of exudate - Regular dressing changes help monitor the wound, assess healing progress and manage exudate levels effectively. - It's important to monitor the patient's pain levels and adjust the medication accordingly to ensure they are getting adequate pain relief. - Reinforcing wound care instructions and providing education on self-monitoring for signs of infection and dressing changes can help the patient manage the wound more effectively. - Documenting findings of all evaluations is crucial for maintaining accurate and up-to-date records of the patient's condition.

WOC Complex Plan of Care

Altered Skin Integrity: . Mild blanchable redness noted to perineal area Braden Score 17 – mild risk The Braden Scale is a standardized, evidence-based assessment toll commonly used in health care to assess and document a patient's risk for developing pressure injuries ("Braden Scale", n.d.).	- Assess skin integrity atleast once per shift. - Encourage patient to report pain over bony prominences - Check heels daily. Off-load when lying in bed. - Use moisture barrier ointment (Critic-Aid Clear Moisture Barrier Ointment, alternative Desitin ointment) in perineal area. - Use low air loss bed - Provide structured mobility plan ("Braden Scale", n.d.). - PT consult - Reposition q 2 h - Record dietary intake and I&O - Nutrition consult - Keep bed linens clean, dry, wrinkle free.	- Regularly monitor and document the patient's skin integrity, pain levels, and mobility. - tracking the patient's mobility and adherence to the structured mobility plan can also help determine if the plan is working as intended. - Patient's skin shows improvement as manifested by improved perineal skin.	- Nursing staff assessment to accurately identify pressure injury (PrI) risk is a hallmark in PrI prevention care (Kennerly et al., 2022). - Assessing skin integrity at least once per shift helps to identify any areas of redness or breakdown in the skin, which can be an indication of pressure ulcers - Encouraging the patient to report pain over bony prominences can also help to identify areas of pressure and prevent the development of pressure ulcers. - Checking the heels daily is important as they are a common site for pressure ulcers to develop. - Using a moisture barrier ointment in the perineal area can help to prevent skin breakdown due to moisture from incontinence. - Using a low air loss bed can help to distribute pressure more evenly - Providing a structured mobility plan and consulting with a physical therapist can help to improve mobility and reduce the risk of pressure ulcers. - Repositioning the patient every 2 hours helps to relieve pressure on any one area and prevent the development of pressure ulcers. - Recording dietary intake and I&O

			and consulting with a nutritionist can help to ensure that the patient is receiving adequate nutrition, which is important for skin health. - Keeping bed linens clean, dry, and wrinkle-free can help to prevent skin irritation and breakdown.
Diabetes Glu 367 A1c 13 According to the National Institute of Diabetes and Digestive and Kidney Diseases (n.d.) the A1C goal for many people with diabetes is below 7.	- Continue monitoring BG 4 times daily as ordered, administer insulin as per sliding scale. - Increase Lantus to 20u at bedtime as ordered According to the National Institute of Diabetes and Digestive and Kidney Diseases (n.d.), - Choose foods that are lower in calories, saturated fat, trans fat, sugar, and salt. - Eat foods with more fiber,	- Evaluate patient's response to the insulin adjustments and antibiotic therapy, as well as the impact of the dietary recommendations - Patient agrees and understands her condition, agrees to adhere to the plan of care -	- Manage hyperglycemia and promote healing of wounds - Monitoring blood glucose levels four times a day and administering insulin as per sliding scale will help to keep blood sugar levels within a healthy range - Increasing Lantus to 20 units at bedtime will provide a basal insulin dose to help maintain stable blood sugar levels throughout the night. - Consulting with nutrition is important to ensure that the patient

	such as whole grain cereals, breads, crackers, rice, or pasta. - Choose foods such as fruits, vegetables, whole grains, bread and cereals, and low-fat or skim milk and cheese. - Consult nutrition - Continue abx as ordered - Engage in open communication to address any concerns or challenges Patient education - Explain the importance of managing blood sugar levels - Discuss the target range for A1c and importance monitoring it regularly - Explained the importance of taking medications as prescribed - Discussed role diet/nutrition in managing diabetes - All questions/concerns addressed - Provide ongoing support		is receiving appropriate nutrition to support healing and maintain blood sugar levels within a healthy range. - Continuing antibiotics as ordered is vital to prevent and treat any infections that may have developed.

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References:

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