WOC Complex Plan of Care

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Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
Patient C.G. is a 72 year old male, alert and oriented x3 admitted for a locally advanced right perforation to his colon secondary to colon cancer. The patient has a history of prostate cancer diagnosed in 2020, ascending colon cancer diagnosed October 2023. Status post IR biliary drains to the right abdomen, which have since been removed due to malfunction and inactivity. The patient also has been diagnosed with failure to thrive. The patient presents with an elevated right hemidiaphragm, swelling to the right side of the abdomen. White blood cell count is 13.48 and increasing each day, Hgb of 7.3, receiving blood transfusion at time of assessment for pre-op stabilization. Albumin is 1.3. Braden score is 12, patient able to move about in bed with assistance. Patient underwent an urgent colostomy, he was marked on 1/8/24 and had surgery later that day. His hospital stay was complicated by an intolerance to food after his colostomy surgery and was placed on a clear liquid diet for nearly a week, finally needing to be placed on TPN. After 2 weeks he was more cachectic in appearance lethargic for most of his days. Ultimately opting for comfort care as the cause for his intolerance to whole food was a metastasis from his prostate and colon cancer to his esophagus and stomach. Due to his condition he was experiencing incontinence, several pressure injuries formed and management of his colostomy were necessary. Patient was once able to use the urinal and ask for the bedpan, now has completely lost all sensation and urge of needing to use the bathroom. With patient's prognosis, end of life hospice and comfort care has been initiated and palliative care is consulted. Deep Tissue Injuries noted to the bilateral heels, occiput, sacrum and bilateral ischium.	**Labs from last visit.** **White blood cell count 15.48 (4-11)** **Hemoglobin 7.3 (13-17)** **HCT: 37 (40-52)** **Albumin 1.3** **Plt: 100 (150-400)** **Na: 140 (135-145)** **Gluc: 100 (65-110)** **K: 3.5 (3.5-5)** **Chlor: 105 (95-105)** **BUN: 9 (8-21)** **Creat: 1.1 (0.8-1.3)** **CT shows mass in abdomen at stomach lining, therefore pt is unable to undergo PEG placement for nutrition.**

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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Braden Score: 13 Sensory Perception- Slightly Limited 3 Moisture- Occassionally Moist 3 Activity- Bedfast 1 Mobility- Very Limited 2 Nutrition- Adequate 3 Friction & Shear- Problem 1 1. Altered skin healing secondary to poor prognosis, decreased nutritional status, immobility and bed bound status and incontinence DTI red, maroon, dark purple in tact skin on pressure points. Bilateral heels both 4x4 Occiput 2x2 Sacrum 5x5 Right ischium 4x4 Left Ischium 4x4 Areas of sacrum and ischium feel boggy to touch.	Patient was placed on TPN for nutrition and for inability to receive PEG tube. Patient able to tolerate clear liquid diet at times when pre medicated for nausea. Mostly enjoying pleasure feeds. Ensure Clear suggested from nutritional consult. Consult to palliative/hospice care. Ensure pressure injury prevention bundle is in place: Molnlycke Tortoise Bed appliance Specialty mattress with alternating air pressure Molnlycke Mepilex Border foams for prevention Coloplast Moisture Barrier cream On DTI areas it is most importan to be offloaded, b/l heels can use 3M Cavillon No sting Barrier Film and Zflex boots to properly offload. Checking for placement in the boots and assessing skin each shift. Reapply Cavillon	Patient identified what/if any clear liquids they enjoy and we continue to “pleasure” feed patient, ensuring mucosa membranes remain moist for comfort, without overloading the patient. Patient remains free of aspiration pneumonia. Education provided to family on having HOB at 45 degrees to allow for proper swallowing, that patient’s mouth and esophagus should be in alignment, no twisting or turning to eat/swallow. Goal for skin integrity to be maintained, does not worsen. Pressure injury prevention measures to be assessed q2 hours when turning and positioning would happen. For hospice patients if it respectful to ask first if they feel up to being turned and positioned.	It is of the WOC nurse’s job responsibilities to maintain and implement a proper Pressure injury prevention plan for their workplace (Borchert, 2021). Creating a uniform system of pressure injury prevention is crucial to the role of the WOC nurse in any facility, maintaining data on how and why pressure injuries occur. For this patient, his prognosis does not lend towards healing these pressure injuries but as a team of nurses and medical professionals, we can do our best to prevent the skin from worsening or more pressure injuries from forming. Especially considering his comfort level, having more skin breakdown will not make him any more comfortable. It’s a fine line between prevention and maintaining comfort but pre medicating, as indicated below will allow for some flexibility.

	when needed. The Sacrum can also use skin prep or if available, Medline Marathon to protect against incontinence and MASD. A Mepilex border foam should be placed for protection and extra cushioning. The Mepilex can be changed every 3 days and rolled down each shift to assess the skin. The occiput can use a Tortoise flexible pillow to mold to the shape of the skull and not place excess pressure on the bony prominence of the skull. A protective Mepilex dressing can be placed and changed every 3 days, rolling down gently to assess skin each shift. The ischium could benefit from Triad wound paste to form a barrier against incontinence and dry out the boggy areas. Triad will help to dry it out while forming a protective layer in an area that is hard to offload completely and especially given this patient's cachetic nature, may be unable to heal.		Patient's score for nutrition is adequate because patient is placed on TPN, this area has no room for improvement because patient will not be able to come off of this type of nutrition. Patient is unable to eat solid foods or return to a regular diet.

2. Risk for altered skin integrity (MASD) secondary to incontinence of urinary system due to loss of urge sensation and control of bladder.	Opting for comfort measure for this patient would give allowance to place Foley catheter in the hospital. Allowing for the patient to remain with dignity and not have to be changed so frequently. Attempt for condom catheter to be placed with no success as patient does not fit condom catheter, Palliative and Hospice care is a qualifier for a Foley Catheter. Alternative is to obtain device, Primofit rather than the condom catheter. Applying it daily for this patient. Steps for Primofit: 1. Perform skin assessment prior to application, trim hair for better seal. 2. Set up suction canister 3. Place patient in supine position, cleanse area with No rinse skin spray and pat dry. 4. Remove Base Adhesive liner and insert penis to device, maintain good seal by applying gentle	Patient remains free from urinary accidents and maintains dignity. No skin breakdown from MASD Urinary incontinence is managed through Foley catheterization of use of external male urinary device. If patient is with Foley catheter, then remains free of UTI for duration of catheter use. Maintain CAUTI prevention methods- These prevention methods include: 1. Drainage bag positioned below bladder and tube without kinks 2. Label with initials of person inserting catheter, date and time. 3. Avoid dependent drainage tube loops 4. Canister labeled with patient name, date and type of fluid 5. Bag below bladder and off of floor 6. Empty if more than 400ml in bag 7. If not urine in bag, bladder	When a patient is on comfort care/ palliative treatment or hospice and is incontinent, a Foley catheter is available to use because it is viewed as a comfort measure. In a typical hospital setting it has been shown not to use Foleys as they are putting the patient at a high risk for a CAUTI. With proper technique and proven prevention methods, up to 50% of CAUTIs can be prevented (Newman, 2021). Patient scored occasionally moist on braden score, if patient has Foley that score may improve.

	pressure all the way around base adhesive 5. Attach suction tubing and set to low, continuous suctioning at min of 40mmHg. Ultimately with this patient on comfort care and looking towards end of life and hospice care a Foley catheter should be placed as a comfort measure.	scan for volume and retention. 8. Anchor catheter to thigh with securement device.	

References:

Borchert, K. (2021). Pressure Injury Prevention: Implementing and maintaining a successful plan and program. In L.L. McNichol, C.R. Ratliff & S.S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 395-423). Wolters Kluwer.

Newman, D. (2021). Indwelling and Intermittent Urinary Catheterization. In J. M. Ermer-Seltun, & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., 404-431). Wolters Kluwer.

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Altered bowel function secondary to new ileostomy. Concern for body image and care provided with patient dignity in mind.	Empty pouch when no more than ½ full. Change appliance every 3-4 days or immediately if leaking. At this time patient is using: Hollister Flat CeraPlus 70mm	No changes to peristomal skin No leakage, or if leakage occurs pouching system is changed immediately	This oval shape of the stoma may lend itself to a higher chance of leaking, given that the seal can be cut improperly due to the shape of the stoma. A given that the patient has an

Ostomy output in the last 24 hours has been high, 2000ml yesterday and since 7am today there has been 800ml. Ostomy team is going to fit the patient for a high-volume appliance with a spout as patient has had an overflowing bag twice since surgery. The loop stoma is budded, with rod in place, oval shaped 2 ¼ inches by 2 inches, may reduce in size, proximal end towards top of loop. Patient prior to current state was uneasy about changing his ostomy device, but willing to learn. In teaching pt's girlfriend, she stated that she couldn't even look at it, which made pt upset and pt confessed damaged his self esteem.	extended wear barrier, cut to fit Hollister 70mm High Output Pouch Convatec Sensicare sting free adhesive Hollister Adapt CeraRing Barrier flat 2" Patient in current state is unable to care for ostomy. Details on how to care of ostomy are detailed as follows for caretakers/staff of hospice care: 1. Gently remove barrier and pouch. May use Adhesive Remover Wipes for easier removal (optional). 2. Clean skin around stoma with warm wet wrung out paper towels, then pat dry. 3. Wrap a barrier ring closely around the stoma (optional). 4. You do not need to cut the ones that are pre-cut. 5. If you are not using pre-cut,	Consider changes to stool consistency as patient continues on hospice, or begins to become more reliant on opioids for pain relief.	excessive output or high output the likelihood for leakage is greatly increased. A high output pouch was attached to account for this. This patient is likely to stay in the hospital for the remainder of their life, given their weakness and instability. Patient has had some very painful days recently, unnecessary movement between hospital and home/in patient hospice would be appreciated by family. Therefore making all adjustments to care in order to fulfill comfort care and palliative recommendations. Given palliative consult pending and ultimately that the patient will continue on to receive pain medications. At present this patient is on a clear liquid diet, all medications were made IV or IVP. Therefore we do not need to worry about absorption. But many of these medications cause constipation, blockage or diarrhea so stool assessment should be closely monitored (Carmel & Goldberg, 2022).

	make sure you cut the barrier to the size of the base of the stoma. 6. Remove backing on barrier and apply to skin over the stoma. Make sure in contact with skin. 7. If there is a paper tape edge, remove that after you attach the pouch to your skin. 8. Close the bottom of the pouch and secure the Velcro tab. 9. ***Only If there is raw red skin or rash around stoma, may use “crusting” technique by applying sprinkling of stoma powder, flatten powder with finger and then gently dab the area with skin barrier wipe. Allow 30 seconds to dry to a tacky crust		

Concerns for pain and comfortability, comfort care and end of life care considerations.	Education on turning and positioning, and using steps to prevent unnecessary break through pain: -Pre-medicate prior to turning and positioning/performing care. -Use guided mediation, imagery, music, distraction to help manage pain.	Desired outcome is to have patient pain free at every ostomy dressing change, during care and during turning and positioning. Validated using FACES when patient is lethargic and numeric scale (1-10) when patient can state if he has pain.	Pain is another factor with profound impact on wound healing. In response to painful stimuli, pain fibers release pain neuropeptides which cause inflammation and decrease ideal conditions for wound healing. A stress response can signal a cortisol rise which can in turn reduce the signaling and production of growth factors (Beitz, 2021).. The patient here is already under the great stress of coming to terms with end of life, the stress of pain on his body is not necessary and will not improve his skin integrity by any means. Patient is on bedrest and has a low mobility score secondary to their weakness and failure to thrive diagnosis. If the patient is able to move more one day, get up to a chair this can be coordinated with the nursing team. Getting the patient OOB to chair will increase their braden score.

References:

Beitz, J. (2021). Wound Healing. In L.L. McNichol, C.R. Ratliff & S.S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 38-55). Wolters Kluwer.

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