WOC Complex Plan of Care

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Specialty Focus: Wound _X_____ Ostomy _____ Continence _____

One complex journal is required for *each* specialty you are enrolled. This assignment evaluates the transition from bedside nurse to that of a specialist/consultant. Critical thinking skills and understanding of evidence based, best practices should be evident. Rationales should be cited and referenced using current APA formatting.

Choose a patient from your clinical experience that exhibits multiple care needs allowing for development of an expanded, holistic plan of care. It is recommended this complex plan of care be your last journal for each specialty enrolled allowing for incorporation of previous instructor feedback. Reach out to your Practicum instructor for any questions.

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
Patient is a 55 year old male with a history of Type 2 diabetes, ESRD on hemodialysis, HLD, HTN, Ileostomy, peripheral artery disease, right below-knee amputee, TIA, and obesity. He presented to the ED on 2/15/2024 for hypertension and swollen, painful testicles that started on 2/11/2024. He was diagnosed with septic shock and atrial fibrillation. It was suspected that he had Necrotizing Fasciitis/Fournier's gangrene. CT scan showed subcutaneous gas. He had exploratory surgery and debridement on 2/15/2024. Tissue culture was obtained from scrotum during surgery. He had primary closure surgery of the wound on 3/25/2024. Penrose drain was placed at that time. Surgery procedure: closure testicles with adjacent tissue transfer 14x10cm. Patient was seen on 3/26/2024 by wound care team for a follow-up visit for unstageable pressure injury to coccyx, surgical closure of scrotum, and diabetic ulcer to left great toe. The measurement of the pressure injury to coccyx was 7cm x 5cm x 0.4cm. There was a small amount of yellow drainage present. The wound shape was irregular with yellow slough present. The periwound was pink. No odor noted. The wound was cleansed with wound cleanser. Mesalt dressing applied to wound bed then covered with Allevyn foam dressing. The scrotum wound was 20 cm in length with approximated sutures. The periwound was ecchymotic. There was a small amount of serosanguineous drainage present. Penrose drain	Labs Sodium 130 Potassium 5.1 Chloride 93 CO2 23 BUN 27 Creatinine 5.34 POC glucose 136 Hemoglobin 10.9 Hematocrit 33.6 WBC 11.03 Platelet count 239 No Hgb A1c noted Scrotal Wound culture: Enterococcus faecalis, Enterococcus avium, bacteroides, enterococcus, and

intact. Wound was cleansed with wound cleanser. ABD pad applied. The measurement of the left great toe wound was 1.2cmx 1cmx 0cm. The wound was round and covered in 100% black eschar with intact periwound. No odor or drainage present. Wound was cleansed with wound cleanser. Mesalt dressing applied, secured with roll gauze. Patient was cooperative with all dressing changes. No questions about his ileostomy, manages himself. Current Medications: Aspirin 81mg chewable daily Atorvastatin 80mg daily B complex, c, folic acid 1mg renal vitamins (Nephrocaps) daily Darbepoetin alfa in polysorbat 40mcg injection (Aranesp) qthurs Gabapentin 100mg noon daily Gabapentin 100mg daily Gabapentin 300mg bedtime Heparin 5,000units q 12 hrs Insulin glargine 6 units daily Insulin lispro injection with meal and hs Loperamide 2mg TID Metoprolol tartrate 12.5mg q12hrs Midodrine 10mg 3 times weekly with dialysis Pantoprazole DR 40mg daily Sevelamer carbonate 1.6g packet before meals 50mL/hr NaCl intravenous infusion Hydrocodone-acetaminophen 7.5-325mg 1 tablet q4 hrs prn hydromorphone 0.5mg injection IV BID prn prochlorperazine 5mg injection q6 hrs prn	mixed anaerobes. CT abdomen/pelvis: Moderate soft tissue gas in the inferior aspect of the left scrotum from the anterior anal triangle region reflecting Fournier's gangrene. Severe vascular calcifications. Nonspecific trace perihepatic fluid, possibly congestive.

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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Unstageable Pressure Injury to coccyx -Covered by 80% of yellow slough Braden Score: Sensory Perception – Slightly limited (3) Moisture – Very Moist (2) Activity – Bedfast (1) Mobility – Very Limited (2) Nutrition – Adequate (3) Friction & Shear – Problem (1) TOTAL: 12 High Risk for Pressure Injury	1.Cleanse wound with wound cleanser or normal saline -Apply mesalt dressing to wound bed -Cover with Allevyn foam dressing -Change dressing daily and PRN if soiled Alternative 2.cleanse wound with wound cleanser or normal saline -Apply adhering hydrocolloid dressing -Change dressing q3 days and prn if soiled 2.Q2 hr turns from left to right keeping patient off the supine position 3.HillRom specialty bed ordered 4. Monitor blood sugar	Slough debrided from wound No increase in wound exudate or odor No pain with dressing changes Periwound continues to be intact with no signs of maceration Nursing documentation show Q 2 hour turns from left to right Nursing documentation shows use of specialty bed	Mesalt is a nonwoven gauze dressing impregnated with sodium chloride. This is a type of mechanical debridement which can be painful and can remove viable tissue so is contraindicated in most cases (Ramundo, 2022). Foam dressing can be used for wounds with small amount of exudate and will help promote autolytic debridement of wound (Jaszarowski & Murphee, 2022). **Alternative dressing**: Hydrocolloids are moisture retentive dressings that can be used for low exudating wounds and promote autolytic debridement, change dressing every 3-7 days (Jaszarowski & Murphee, 2022). The pressure injury prevention plan should include off loading the pressure so that the tissue can receive an adequate blood supply (Edsberg, 2022). Patient should be placed on a specialty bed that alternates pressure and controls temperature and humidity since patient is at a high risk for pressure injuries according to braden score. This would be a mattress with low air loss and alternating pressure (Mackey & Watts, 2022). Hyperglycemia can impair wound healing at every stage and therefore should be

			controlled (Beitz, 2022).
Surgical closure of scrotum -primary closure – stiches are approximated -penrose drain present	1.cleanse wound with wound cleanser or normal saline -apply abd pad -change daily or prn when soiled Alternative 2.Cleanse wound with wound cleanser or normal saline -apply antimicrobial dressing (primaseal Ag+ post op dressing) -remove 48-72 hrs after surgery	Wound heals normal without dehiscence or signs of infection	The postoperative dressing will act as a barrier from contamination and absorb any exudate which can be removed within 48-72 hours depending on if there is epithelial resurfacing (Brindle & Creehan, 2022). Patient has diabetes and obesity which can increase the risk of infection so an antimicrobial dressing may be indicated (Brindle & Creehan, 2022)
Diabetic foot ulcer to left great toe -covered by dry black eschar 100%	1.cleanse wound with wound cleanser or normal saline -apply mesalt -wrap with gauze -change daily Alternative 2.cleanse wound with wound cleanser or normal saline -Apply no sting barrier spray (cavilon) to periwound, allow to dry -apply adhesive hydrogel dressing -change q3 days 3. Off load pressure by floating heel using pillow or wedge	No signs of infection Black eschar debrided from wound Periwound skin shows no signs of maceration Nursing documentation shows heel was off loaded	Mesalt is a nonwoven gauze dressing impregnated with sodium chloride. This is a type of mechanical debridement which can be painful and can remove viable tissue so is contraindicated in most cases (Ramundo, 2022). Alternative dressing: Hydrogel sheet dressing can be used in dry wounds to promote autolytic debridement (Jaszarowski & Murphree, 2022). Periwound skin should be protected from maceration when using a hydrogel dressing (Jaszarowski & Murphree, 2022). The pressure injury prevention plan should include off loading the pressure so that the tissue can receive an adequate blood supply (Edsberg, 2022).

References:

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Jaszarowski, K. & Murphree, R. W. (2022). Wound cleansing and dressing selection. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 157-171). Wolters Kluwer.

Mackey, D. & Watts, C. (2022). Therapeutic surfaces for bed and chair. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 425-445). Wolters Kluwer.

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