WOC Complex Plan of Care

Name: _____Hannah Peterson _____ Date: ____5/1/24_____

Clinical Focus: Wound __x__ Ostomy ____ Continence ____

Number of Clinical Hours Today: __8__

One complex journal is required for *each specialty you are enrolled/registered.* 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 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
CG is a 54-year-old male being seen with an admitting diagnosis of urinary tract infection (UTI). The patient is known to the wound care team from previous admissions and was last seen on 4/19/24. CG was admitted with the following sounds: Sacrum- stage 4, right buttock- stage 4, and bilateral groin- contact irritant dermatitis related to urinary incontinence. Wound measurements: Sacrum- 5 cm x 6.5 cm x 4.5 cm with 6 cm tunnel at 3 o'clock. Right buttock- 13 cm x 8.5 cm x 5.5 cm. 7 cm tunnel present at 1 o'clock. The right buttock wound base is tan slough and some worsening peri wound tissue damage noted. The sacrum wound base is pink. Moderate amount of yellow drainage present from both wounds. The sacrum and right buttock wound communicate; there is a 4 cm skin bridge between the wounds. During assessment, a full thickness wound with a pink wound bed measuring 1.5 cm x 2 cm x 1.7 cm was noted around CG's suprapubic catheter and urine was noted to be leaking almost continuously from his penis. The patient was lethargic and unable to answer the wound care team's questions regarding the wounds. Plan of Care- all wounds cleansed with surfactant and gauze. Sacrum and right buttock wounds- alcohol-free Essenta skin barrier wipes applied to peri wounds. Wounds lightly packed with Vashe-soaked Kerlix roll gauze. Covered with ABD pads and secured with silicone tape. Dressings to be changed twice daily. Suprapubic wound- Aquacel hydrofiber to be changed twice daily and as needed.	See Braden Scale assessment below T12 paraplegia following gunshot wound in 1993, neurogenic bladder and chronic suprapubic catheter with frequent UTIs Bilateral AKAs "in the 2000s" Previous admission 4/18/24 – 4/23/24 complicated UTI – MDR E. Coli Arcanobacterium haemolyticm grew in sacral wound and 1 of 2 blood cultures. No cultures obtained on this visit. Readmission 4/30/24 CBC with WBC 21 Lactate 1.7

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The patient has an established loop sigmoid colostomy. He presented to the ED on 4/30/24 with no pouch in place. The stoma is in the left lower quadrant, round, 1 3/8" in diameter, budded, red, and moist. The mucocutaneous junction is intact. The peristomal skin is clear and intact. The peristomal contour is flat with a notable bulge to lateral edge (1-5 o'clock). Supportive tissue is soft. Output is thick brown liquid. Recommendations for pouching system: 2 ¼" Hollister New Image convex cut-to-fit flange. Hollister Adapt CeraRing. Drainable pouch. Wear time goal: 3-7 days.	Chest X ray no acute process CT with brain no acute process Other labs: A1C 4.3 as of 3/23/24 WBC 14.72 as of 4/30/24 Hemoglobin 8.2 as of 4/30/24 Hematocrit 27.5 as of 4/30/24

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Continuous urine leaking from penis despite suprapubic catheter	Consult urology Maintain suprapubic catheter; follow institution protocol related to cleansing. Follow CAUTI protocol.	Consult placed to determine cause of and reparability of urine leakage	Urine leaking from penis while suprapubic catheter is in place is not within normal limits. The patient is always moist from urine which does not promote wound healing by keeping the skin too moist which reduces tensile strength and the pH of urine is too acid which breaks down the skin (Lund & Singh, 2022).
Full thickness wound present around suprapubic catheter	Apply Aquacel hydrofiber to wound bed and change twice daily and as needed.	Wound size decreasing	Alternative dressing: Dry island dressing (gauze and tape)
Two stage 4 pressure injuries	Cleanse sacrum and ischium wounds with surfactant and gauze. Protect peri wound with alcohol-free silicone wipe. Fill wounds with Vashe-soaked Kerlix roll gauze.	Wound sizes decreasing Wound edges no longer white from moisture	Vashe is made with hypochlorous acid which is naturally produced in the body, making it less cytotoxic than other wound cleansing solutions (Jaszarowski & Murphree, 2022).

Braden Score Sensory Perception – Very Limited (2) Moisture – Constantly Moist (1) Activity – Chairfast (2) Mobility – Very limited (2) Nutrition – Adequate (3) Friction and Shear – Problem (1) **Total**: 12 – High Risk for Skin Breakdown Existing pressure injuries automatically makes patient very high risk for pressure injuries	Cover wounds with ABD pads. Secure with skin-safe tape. Change twice daily and PRN. Notify wound care team if changes noted (increased exudate, increased nonviable tissue, etc.) Reposition patient every 1.5 – 2 hours using wedges to offload sacrum Place patient on Dolphin bed to redistribute pressure and improve microclimate. Limit layers between bed and patient to promote microclimate. Decrease friction and shear by using low-friction Medline sheet, keep head of bed at 30 degrees or less	Floor nurses' notes indicate that patient is being turned q 1.5-2 hours	

References:

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. 157-169). Wolters Kluwer.

Lund, C., & Singh, C. (2022). Skin and Wound Care for Neonatal and Pediatric Populations. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 233-256). Wolters Kluwer.

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Content		Possible Points	Awarded Points	Comments
Summary of Selected Patient	Summarizes pertinent medical and surgical history	2		
Assessment	Describe assessment findings	6		
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	6		
	Wound and Continence Case Study Journal: Using the Braden scale, assess for pressure injury risk. **You must submit your completed Braden risk assessment with your care plan.	5		
Planning	Formulate a comprehensive management plan based on the assessment and the specialty (wound, ostomy, or continence) needs. **Wound and Continence Case Study Journal:** Include specific Braden sub-scale scores	12		
	Propose alternative products. Include generic & brand names	4		
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6		
Rationale	Explain the rationale for identified interventions	6		
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1		
	Proper grammar & punctuation used	1		
	References: See the course syllabus for specific requirements on references for all assignments	1		
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50			

Additional comments:

Reviewed by: _____ Date: _____