

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
<p>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?:wounds: 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.</p>	<p>See Braden Scale assessment below</p> <p>T12 paraplegia following gunshot wound in 1993, neurogenic bladder and chronic suprapubic catheter with frequent UTIs</p> <p>Bilateral AKAs "in the 2000s"</p> <p>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.</p> <p>Readmission 4/30/24 CBC with WBC 21 Lactate 1.7 Chest X ray no acute process</p>

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<p>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.</p>	<p>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</p>
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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Continuous urine leaking from penis despite suprapubic catheter	<p>Consult urology Maintain suprapubic catheter; follow institution protocol related to cleansing. Follow CAUTI protocol. <u>Apply external condom catheter to penis to contain urine.</u></p> <p><u>In the meantime, can you use a condom cath to keep pt. dry?</u></p>	<p>Consult placed to determine cause of and reparability of urine leakage</p>	<p>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).</p>
Full thickness wound present around suprapubic catheter	<p>Apply Aquacel hydrofiber to wound bed, <u>cover with gauze and tape</u> -and change twice daily and as needed. <u>What is your secondary? Is urine leaking here? The WOC preceptor believed it to be pressure related. No urine was identified leaking from the suprapubic wound.</u></p>	<p>Wound size decreasing</p>	<p>Alternative dressing: 3M Medipore Dry island dressing (gauze and tape)</p>
Two stage 4 pressure injuries	<p>Cleanse sacrum and ischium</p>	<p>Wound sizes decreasing Wound edges no longer white from moisture</p>	<p>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). <u>Even though this this patient is hospitalized, doing twice a day dressings exposes the wound to air.</u></p>

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<p>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</p> <p><u>Ok, you are using skin prep for moisture, what is up w chair, turning for mobility, nutrition is adequate which is surprising, friction & shear is a problem which you addressed w Medline sheet. Address chair situation, yes or no & would pt. benefit w PT consult?</u></p> <p>Existing pressure injuries automatically makes patient very high risk for pressure injuries <u>not per the scale but in general, yes</u></p>	<p>wounds with surfactant and gauze. Protect peri wound with alcohol-free silicone wipe. Fill wounds with Vashe-soaked Kerlix roll gauze. 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. <u>Ok, so no OOB? Do you want patient to be on back? Limit sitting in chair to meals.</u></p> <p><u>You did not answer the alternative from a topical therapy perspective. What else can be done w the two pressure injuries?</u></p> <p><u>Alternative therapy for pressure injuries: 3M/Soventum V.A.C. Negative Pressure Wound Therapy. Change dressing three times a week. Cleanse wounds with Vashe-soaked gauze for 5-10 minutes. Remove. Pre-drape peri wound with occlusive VAC foam. Apply white foam to exposed structures. Fill space with black foam. Bridge VAC head to lateral leg. Maintain pressure at -125 mmHg.</u></p>	<p>Floor nurses' notes indicate that patient is being turned q 1.5-2 hours.</p>	<p><u>perhaps has some pain involved for the patient, and is definitely time intensive for the nursing staff. Nothing was mentioned about odor or purulent drainage, so perhaps this particular type of antimicrobial is not necessary for this wound. Think about other antimicrobial dressings in your own practice that might be used that would be less time intensive for the nursing staff and yet very effective for bioburden in the wound, as all wounds are contaminated & colonized.</u></p> <p><u>The patient expressed having no sensation related to his T12 paraplegia, see above. The drainage was yellow, please see above.</u></p>
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		<p><u>Another alternative dressing for the sacral and ischial pressure wounds would be to fill the space with Kerlix roll gauze impregnated with polyhexamethylene biguanide (PHMB)</u></p> <p>Place patient on Dolphin bed to redistribute pressure and improve microclimate. Limit layers <u>when actually writing for staff be specific</u> between bed and patient to promote microclimate. <u>Use only an absorbent pad, Medline sheet, and bed sheet between the patient and the bed.</u></p> <p>Decrease friction and shear by using low-friction Medline sheet, keep head of bed at 30 degrees or less</p> <p><u>Consult physical therapy to improve transfers and patient mobility.</u></p>		<p><u>Polyhexamethylene biguanide (PHMB) is a broad-spectrum antiseptic that prevents most strains of bacteria from reproducing by destroying their phospholipid membrane and DNA replication mechanism (Niro et al., 2022). It also impedes virus and fungi growth (Niro et al., 2022). “PHMB is currently considered one of the most suitable antiseptics for chronic wounds... it does not inhibit the reepithelization process and also prevents secondary bacterial infection” (Niro et al, 2022).</u></p>
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References:

Jaszarowski, K., & Murphree R. W. (2022). Wound **c**leansing and **d**Dressing **s**election. 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.

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Lund, C., & Singh, C. (2022). Skin and [wWound cCare for nNeonatal 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. [good find for that info! But, Hannah, for your other complex journal use at least one or two other sources for your work in addition to the book](#)

[Niro, A., Pignatelli, F., Fallico, M., Sborgia, A., Passidomo, F., Gigliola, S., Nacucchi, A., Sborgia, G., Boscia, G., Alessio, G., Boscia, F., Addabbo, G., Reibaldi, M., & Avitabile, T. \(2022\). Polyhexamethylene biguanide hydrochloride \(PHMB\): Properties and application of an antiseptic agent. *European Journal of Ophthalmology*, 33\(2\), 655–666. <https://doi.org/10.1177/11206721221124684>](#)

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Content		Possible Points	Awarded Points	Comments
Summary of Selected Patient	Summarizes pertinent medical and surgical history	2	<u>2</u>	
Assessment	Describe assessment findings	6	<u>5</u>	Suprapubic wound
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	6	<u>6</u>	
	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	4	
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	<u>9</u>	Missing information
	Propose alternative products. Include generic & brand names	4	<u>0</u>	Missing
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	<u>5.5</u>	
Rationale	Explain the rationale for identified interventions	6	<u>5.5</u>	
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1	<u>.5</u>	
	Proper grammar & punctuation used	1	<u>1</u>	
	References: See the course syllabus for specific requirements on references for all assignments	1	<u>.75</u>	
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50		<u>32.25</u>	

Additional comments: [Hannah, just a few things left undone. The major item missing is the alternative plan w products.](#)

Reviewed by: Patricia A. Slachta Date: 5/3/24