WOC Complex Plan of Care

Paige, the highlighted areas below need to be completed. I am not sure how you used a form that did not have the rubric attached. I copied your work onto this form.

Name: Paige Newquist **Date:** 5/15/24 is this the date you cared for the patient? If not, then please change the date to the date of care

Clinical Focus: Wound __X__ Ostomy ____ Continence ____

Number of Clinical Hours Today: __8__

One complex journal is required for each specialty in which 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
Pt is a 66 yo female admitted on 4/7/2024 with an extensive PMH. Relevant PMH includes anxiety, LBP, colorectal cancer, constipation, COPD, depression, DM, HTN, groin abscess, HLD, lymphedema, breast cancer, sleep apnea, and SOB. Pt is also a smoker. Past surgical history includes bladder repair, colon resection, colonoscopy, cystoscopy, endoscopy, liver biopsy, liver resection, radiation, sigmoidoscopy, lumpectomy with sentinel node biopsy, sacral wound debridement and flap reconstruction, hemorrhoid excision, thoracic decompression and fusion, and upper GI endoscopy. Pt was brought to the ER by recommendation of her nursing home provider for a worsening sacral wound. Wound care was previously managed by the nursing home, dressing change therapies are unknown. Pt was transferred to this hospital from another local ER for further evaluation. Pt was last seen at this facility in December 2023 and the sacral wound was healing. Pt was readmitted in 4/7/2024 with flap failure from a debridement, flap, and hemorrhoidectomy performed in 12/2023. Pt reported buttock pain, feeling unwell, fever, and chills. Tissue necrosis was present with an unstageable PI. Wound found to contain heavy colonization of corynebacterium species and scant E. coli. Pt received Vancomycin and dx of osteomyelitis. Incisional and sharp debridement performed on 4/9/2024. Full tissue necrosis, sacral abscess, and undermining found. Wound now dx as a stage 4 PI measuring 5x3.5 cm. No depth or undermining measurements noted.	April 7, 2024 CBC (no diff) WBC- 12.23 RBC- 4.20 Hgb- 9.9 Hct- 33.5 Platelets- 285 BMP Glucose- 88 BUN- 8 Creatinine- 0.31 Sodium- 145 Potassium- 3.5 Chloride- 107 CO2- 28.0

Wound care was consulted postoperatively for stage 4 sacral PI. Upon re-assessment on 5/15/2024, pt is A&Ox4, GCS-15. Pt is obese with soft abdomen, PERRLA, RR-17, room air, and appears to be comfortable. Skin is dry and elastic with stage 4 PI to the sacrum. Regular diet and thins??. Increased pain with turning and palpation to sacral PI. Wound vac was changed with 200mL sanguineous output noted in the canister. NPWT dressing was removed with adhesive remover. Periwound skin and wound cleansed with gauze and NS. Periwound skin intact and no signs of breakdown. Small amount of sanguineous discharge when cleaning. Wound bed is granulating with beefy red tissue, bone palpated, and small amount of slough around wound edge from 3-6 with slight epibole. Undermining present from 12-2 with depth up to 3.5 cm. Wound measures 4.25x3.75x2 cm. Wound dressed and lightly ~~packed~~ filled with black foam, draped, and attached to continuous NPWT suction of 125mmHg. Trackpad was bridged to the L lateral hip and skin outside the wound protected with drape so bridging foam did not come in contact with healthy skin. External hemorrhoid foam medication applied to anus by request of RN because of the pt's previous refusal to turn. Peri wick Do you mean PureWick? use noted. No IAD, MASD, or device-related breakdown present in perineal areas. Pt tolerated the visit and care well. No discomfort post-dressing change voiced.

<u>Current Medications:</u>
Acetaminophen 1000mg PO q8hr
Amitriptyline 10mg PO daily
Apixiban 2.5mg PO BID
Brimonidine 0.2% ophthalmic solution, 1 drop, both eyes, BID
Cholecalciferol 2,000U PO
Docusate sodium 100mg PO BID
Ferrous sulfate 325mg PO daily
Fluticasone 50mcg/act nasal spray, 1 spray, daily
Guaifenesin 600mg PO BID
Insulin lispro (sliding scale), before meals (ACHS + 2am)
Lidocaine 4% patch, 1 patch, BID
lubiprostone 24mcg POI BID
Montelukast 10mg PO daily
Naloxegol oxalate 25mg PO daily
Pantoprozole 40mg PO daily

Calcium- 8.9
BUN/Creatinine ratio- 25.8

<u>Misc</u>
Protein- 5.7
Prealbumin- 9.3
Albumin- 2.9
Lactate- 0.7
HgbA1C- 6.2

<u>Wound Culture:</u> Negative (most recent)
**Previous: scant E. coli and heavy corynebacterium species colonization

<u>Blood Culture:</u> Negative

<u>CT Pelvis (Admission):</u>
–Ill-defined fluid collection, 4x4x1.5 cm in presacral soft tissues. Density found in the posterior aspect of sacrum within the fluid collection, concern for osteomyelitis.

–No air or gas bubbles and no abnormal bowel loop dilation. No urinary bladder distension. Anterior abdominal wall intact.

<u>CT Abdomen/Pelvis (4/18/2024)</u>
–Streak artifact from thoracic fixation hardware. No new liver lesions. Arenal nodules unchanged.

–Tiny gallstones present, no cholecystitis or

MiraLax 17g packet PO daily Polyethylene glycol 1% ophthalmic solution, 2 drops, both eyes q6hr Potassium chloride 10mEq PO BID Pramoxine HCL rectal TID Pregabalin 200mg PO BID Rosuvastatin 40mg PO daily Saccharomyces boulsrdii 250mg PO daily <u>Wound Care Recommendations:</u> –Continue NPWT continuous suction 125mmHg, black foam, change 3x/week –Wound care will reassess pt regularly. –Nursing: Monitor output q12h –Call wound care if leaking from wound vac or if system is off for longer than 2hrs	biliary dilation. Pancreas, spleen, and kidneys are unremarkable. No acute bowel abnormalities. 2.5cm lipoma in ascending colon. –New R adnexal cystic mass, 8.8x5.7 cm. Uterus and L ovary unremarkable. Gyn-Onc follow-up recommended. –Deep decubitus ulcer within the large open wound with packing extending to the inferior sacral cortex, osteomyelitis cant be ruled out. Prominent presacral edema with slightly larger sliver of presacral fluid noted, no fluid collection. <u>Lumpectomy biopsy</u> –cT3N1 grade 3 triple negative breast cancer on right <u>Stool Culture:</u> Not performed

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
<u>Stage 4 PI</u> –Beefy red granulating muscle/tissue, bone palpated, small amount slough along borders, andslight epibole. –95% granulating tissue, 5% slough –Undermining from 12-2, up to 3.5cm –Measurements: 4.25x3.75x2 cm –Periwound skin intact, no redness –Hemorrhoids to anus	1- Clean wound and periwound skin with NS and gauze –Fill sacral PI with black foam and cover with drape. Place to 125mmHg continuous NPWT – Change NPWT system 3x/wk – Notify wound care if leakage is present or NPWT is off for more than 2 hours. 2- Place pt on immersion therapy bed	–Wound is granulating with beefy red tissue Just a note about beefy red. Beefy red tissue may often actually be friable... In other words, It bleeds easily when touched. That is usually indicative of excessive bioburden and bacteria in the wound and is not really a positive sign. We want tissue to be red, but we don't want it to bleed easily. –Decreased slough and nonviable tissue present from previous photo in pt's	1- NPWT uses foam to promote wound healing by reducing edema, resulting in increased blood flow to the PI (Nix & Bryant, 2022). Pt currently only uses black foam within the PI NPWT dressing. *<u>Alternatives:</u>* –Use of a silicone fenestrated contact layer in the NPWT dressing Contact layers can reduce adherence

–Skin is dry <u>Braden Score</u> Sensory Perception: Slightly Limited- 3 Moisture: Occasionally Moist- 2 Activity: Bedfast- 1 Mobility: Very Limited- 2 Nutrition: Adequate- 3 Friction and Shear: Problem-1 *Total*- 11: Moderate Risk Mobility & activity are low scores. As a wound nurse, you know the importance of mobility for a variety of body systems so what consults should occur? Why can't staff get pt OOB for brief periods? Why can't she ambulate? The pt's current PI and comorbid conditions make this pt high risk for PIs though they scored in the moderate risk category on the Braden Scale. Pt has limited movement capabilities, pain with movement, and little desire to move with a record of refusals to turn.	3– Turn pt q2hrs using pillows to reduce pressure on sacral PI. Float heels when supine on pillows. 4– Maintain HOB at 30 degrees or less 5– Consult dietetics for consult on increased protein intake to aid wound healing and follow given recommendations. 6– Monitor blood glucose levels and maintain within normal range with ordered low correction sliding scale insulin. Based on the slight bleeding when cleansing, this wound should have an antimicrobial dressing as a contact layer. Acticoat Flex allows NPWT to be used over it & fluid to be pulled through while delivering adequate amounts of silver to the wound bed to minimize bacteria. White foam is most helpful in tunnels & tracts as it is denser & comes out in one piece. If facility uses instillation therapy, would this have a place for this patient?	chart –Wound is shrinking from previous serial measurements –Periwound skin is intact –No rash or redness. Skin is dry. –Chart dictates that pt is being turned every 2 hours.	and ingrowth to viable tissues and decrease pain during dressing changes (Lund & Singh, 2022). Use of contact layers also reduces trauma, bleeding, and length of time it takes to change the NPWT system (Lund & Singh, 2022). –Use of a hydrophobic white sponge with black foam Hydrophobic white foam can be used when there is uneven healing (Lund & Singh, 2022). The presence of both granulating tissues, slough, and undermining within this pt's wound may indicate differing healing rates, indicating that use of hydrophobic white foam may be beneficial. Only areas with more active granulation should have white foam to slow granulation, and less active areas should receive a contact layer and black foam to promote equal rates of granulation throughout the wound (Lund & Singh, 2022). When equal rates of granulation are present, change to only a contact layer and black foam and discontinue use of the hydrophobic white foam (Lund & Singh, 2022). 2- Pt uses an air-fluidized bed by Hillrom *<u>Alternative:</u>* –Use of Immersion Therapy by Agiliti Immerse Low Air Loss Mattress

			Support surfaces have a goal to reduce pressure intensity and prevent PIs by pressure redistribution (Mackey & Watts, 2022). Immersion therapy beds help spread pressure over the contact area and reduce pressure concentration on bony prominences, such as the sacrum (Mackey & Watts, 2022). 3- Off-loading heels with pillows can help prevent PI (Borchert, 2022). Research suggests turning patients every 2-4 hours on effective mattresses can help prevent PI in patients with limited mobility (Borchert, 2022). 4- Maintaining the HOB at or less than 30 degrees can prevent sliding, help facilitate breathing, and reduce PI risk (Borchert, 2022). Care should be provided to reduce slumping, as this can increase pressure on the sacrum (Borchert, 2022). 5- High protein supplements and fortified foods should be offered to patients with PIs in addition to their regular diet (Friedrich, Posthauer, & Dorner, 2022). 6- Patients with diabetes have increased risk for wounds, and glycemic control can impact wound healing (Friedrich, Posthauer, & Dorner, 2022). In older adults, the glycemic goal should be 90-130 mg/dL, and poorly controlled blood

			sugar increases the patient's risk for impaired wound healing and infection (Friedrich, Posthauer, & Dorner, 2022).

References

Borchert, K. (2022). Pressure injury prevention: Implementing and maintaining a successful plan and program remember that the chapter titles are written in sentence format so Pressure injury prevention: Implementing and maintaining. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 396-424). Wolters Kluwer.

Friedrich, E., Posthauer, M. E., & Dorner, B. (2022). Nutritional strategies for wound management. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 234-256). 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. 234-256). 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.

Nix, D. & Bryant, R. (2022). Fistula management. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 793-813). Wolters Kluwer.

As faculty, we do value our textbooks for sure, but for assignments, use some other resources too.

WOC Complex Plan of Care

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: _____