WOC Complex Plan of Care

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Specialty: Wound • Ostomy ☒ Continence •

One complex journal is required for *each* specialty in which 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
96-year-old male with history of rectal cancer. s/p robotic-assisted laparoscopic APR with end colostomy 6/11/2020. TNM – T3 N1 M0. He had neoadjuvant chemoradiation from 2/3/20-2/7/20. PMH: HTN, Pulmonary HTN, Microcytic Anemia, Arthritis. The patient presented to the hospital for prolapsed colostomy and concern for recurrent rectal cancer with a planned revision of his colostomy. POD #1 Colostomy revision. Findings: Large fungating friable mass of the ascending colon and on the mucosa of the prolapse of the colostomy with concerns for obstructing the colostomy. The mass was resected, and the stoma was reconstructed. LLQ Colostomy: Budded, round, moist, beefy red stoma. Urostomy pouch noted to the site. Unable to exchange the pouch for a Lock N' Roll. The flange was also removed. Peristomal skin intact. Maroon, intact non-blanchable area noted consistent with a DTI from 5 O' Clock to 7 O' Clock measuring 0.3x4cm. Etiology from convex flange. There is a hyperpigmented discoloration noted from 1 O' Clock to 2 O'Clock. Cavilon Barrier film applied to the peristomal skin. The pouching system was changed to Hollister two-piece fecal ostomy pouching system (2 3/4") with a flat flange. The patient was made aware of the findings. A full skin assessment was then performed including all bony prominences due to Braden scores of 18 and patient bring post-op. Bilateral heels and sacrum/coccyx were intact. No other wounds noted. The nurse was notified of the assessment findings and wound care plan. The provider was also notified of the assessment findings.	Labs from: 5/53/2024 WBC: 8.07 k/uL Hgb: 8.2 gm/dL Low Hct: 29.5 % Low Platelet: 278 k/uL RBC: 4.38 million/uL Neutro %: 91.8 % High Lymph %: 4.3 % Low Sodium Lvl: 140 mmol/L Potassium Lvl: 3.7 mmol/L Chloride: 109 mmol/L High CO2: 22 mmol/L BUN: 9 mg/dL Creatinine: 0.69 mg/dL Glucose Lvl Random: 121 mg/dL Calcium Lvl: 8.8 mg/dL Magnesium Lvl: 1.9 mg/dL Phosphorus Lvl: 3 mg/dL

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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Alteration in bowel function secondary to colostomy revision Stoma measures 35mm. Round, moist, beefy red, Os located center in the stoma. Mucocutaneous junction intact. Peristomal skin intact. Maroon, intact non-blanchable area noted consistent with a DTI from 5 O' Clock to 7 O' Clock measuring 0.3x4cm. Etiology from convex flange. There is a hyperpigmented discoloration noted from 1 O' Clock to 2 O'Clock. The patient is sitting. Abd flat, free of creases & scars, firm to touch.	Use flat two-piece drainable pouching system: ~ Hollister flat two-piece fecal ostomy Lock ‘n Roll pouching system Blue (2 3/4") ~ Hollister Two-Piece Flange, Flat Blue (2 3/4") Alternate pouching system: ~ Hollister flat one-piece fecal ostomy Lock ‘n Roll pouching system Blue (2 3/4") Provide the patient with supplies to change the pouching system every 3 days. Assist with changes if needed due to pain or medical acuity. **Supplies Needed: ~ Hollister Pouch two-piece fecal ostomy pouching system Blue (2 3/4") ~ Hollister Two-Piece Flange, Flat Blue (2 3/4") ~ Washcloths & Towel ~ Stoma measuring guide ~ Ostomy Scissors ~ Graduated Cylinder ~ Cavilon Barrier Film	Pt able to return to caring for ostomy Pt/nurse verbalize no leaking from the pouching system Improvement in the peristomal DTI	A flat barrier is indicated if the area around the stoma is flat all the way around the stoma. (Colwell, J. & Hudson, K,2022) Pressure injuries can be caused by belts, binders, and firm convex flanges. Length, width & depth of the wound should be documented as well as color. The cause of the PI should be removed and an alternative pouching system may be necessary. (Salvadalena, G. D. & Hanchett, V., 2022)

	~Empty pouch prior to change. ~Remove old appliance starting at the top and discard. ~Cleanse stoma and peristomal skin with warm water and a washcloth ONLY. (Do not use soaps or creams on the skin as it will prevent pouch from adhering to skin). ~Dry skin well. Apply Cavilon Barrier Film peristomal skin. ~Measure stoma and cut flat wafer to size. Place and snap together the pouch to flange prior to placing over ostomy to prevent pressing down on new ostomy site. ~Place the patient's hand or warm washcloth over the ostomy pouch to assist with creating a good seal. ~Document care and any output - Change Hollister two-piece fecal ostomy pouching system (2 3/4") every 3 days while in house and **immediately, if leaking**. - Assess stoma appearance and document every shift. - Assess output in pouch, measure and document		

	throughout shift. - Empty pouch when 1/3 to 1/2 full. - Assess peristomal skin during pouching changes. Monitor progression of DTI. Notify WOC RN if wound worsens, i.e. increases in size, becomes an open wound, develops slough, etc.		
Pain Control	Assess pain prior to pouching change using the numeric pain scale. Medicate with pain medication as ordered by LIP. Re assess after 30 minutes for IV medications or 60 minutes for PO medications.	Patient reports pain 0-3 on numeric pain scale after pouch change.	Pain causes the release of cortisol and catecholamines which cause vasoconstriction, decreased immunity, and wound strength compromising wound healing. (Thabet, T., 2023) Pain can cause decreased ability to independently perform ADLs. Patients report decreased quality of life due to “sleep disturbance, poor appetite, functional decline, and/or psychosocial maladjustment (Woo, K. & Sibbald, R. G., 2020, p. 308).”
Nutrition	Dietary consult for nutrition	Patient is able to maintain adequate	A registered dietician should be

	assessment and diet instruction for post-op wound healing and preparation for cancer treatment.	intake of calorie and protein requirements as determined by the RDN.	consulted for patients at risk for or exhibiting malnutrition. They can use nutritional assessments to determine if a nutritional problem exists. malnutrition (Friedrich, E., Posthsuer, M. E. & Dorner, B., 2022)
	Biochemical data for evaluation of serum albumin & pre-albumin levels	Serum albumin & pre-albumin levels WNL.	Serum albumin & pre-albumin levels are used to determine visceral protein levels. They are used in combination with the patient's overall health, intake and wight to determine nutritional status. (Friedrich, E., Posthsuer, M. E. & Dorner, B., 2022)
	Weekly weight monitoring	Maintains current weight	Unintended weight loss is an indication of malnutrition (Friedrich, E., Posthsuer, M. E. & Dorner, B., 2022)

References: APA Format

Colwell, J. & Hudson, K (2022). Selection of pouching system. In Carmel, J., Colwell, J., & Goldberg, M. T. (Ed.) *Wound, ostomy, and continence nurses society core curriculum ostomy management* (2nd ed., pp. 172-188).

Friedrich, E. Posthauer, M. E., & Dorner, B. (2022). Nutritional strategies for wound management. In McNichol, L. L. Ratliff, C. R., & Yates, S. S. (Ed.), *Wound, ostomy, and continence nurses society core curriculum wound management* (2nd ed., pp. 116-135).

Salvadalena, G. D. & Hanchett, V. (2022). Peristomal skin complications. In Carmel, J., Colwell, J., & Goldberg, M. T. (Ed.) *Wound, ostomy, and continence nurses society core curriculum ostomy management* (2nd ed., pp. 250-269).

Thabet, T. (2023, March 3). *Wound pain: do you know the physiology?*. Retrieved June 9, 2024, from https://www.woundsource.com/blog/wound-pain-do-you-know-physiology

Woo, K. & Sibbald, R. G. (2020). *Pain management and wounds.* In Baranoski, S. & Ayello, E. A. (Ed.) *Wound care essentials practice principles* (5th ed., pp. 306-332).