WOC Complex Plan of Care

Name: ____Unni Mary Kurian_____ Date: __6/13/24_____

Clinical Focus: Wound _☑___ Ostomy _☑___ Continence ____

Number of Clinical Hours Today: _10___

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
AW is a 51-year-old male with a previous medical history of ESRD on HD MWF (via RUE AVF, LUE AVF c/b L subclavian steal syndrome s/p L 4th/5th distal phalange amputations), T2DM and HTN, who initially presented to an outside hospital on 3/14 for L foot pain; however, during workup, was found to have severe AS, NSTEMI secondary to CAD, and RV dysfunction with pulmonary hypertension. He was transferred to this facility for surgical consideration and evaluation of cardiac issues and performed a ROSS procedure and CABG on 4/2. He has had a complex hospital course with multiple complications, including cardiopulmonary arrests, cardiogenic shock with severe RV dysfunction, L BKA, mesenteric ischemia, ESRD on CRRT and now iHD, sternal wound dehiscence and sacral wounds, as well as ongoing melena. The patient is currently admitted to CVICU. Patient alert and responding to commands. On regular diet and Ensure twice daily and on tube feeding tube Nepro trickle via DHT (kept on hold due to abdominal pain).The patient is placed on a rectal tube for the Malena and ongoing watery stool. As per the GI team, they do not recommend any scope now due to suspicion of bowel hypoperfusion in the setting of hypotension. The patient is on continuous octreotide infusion. The patient is also receiving Darbepoetin alpha weekly, and 3 PRBC units have been transfused. Plan	06/12/2024 Sodium 142 Potassium 4.0 Chloride 109 CO2 23 BUN 14 Creatinine 2.91 (H) Calcium 8.5

for transfusion if Hb is less than 7. The patient was initially intubated and was on Levophed infusion. Extubated on 5/31/24 and is now on room air and BiPap at night, and Levophed was stopped on 6/11/24. Patient was initially on IV antibiotics (Zosyn 5/30-6/6). Blood cultures on 5/31 and 6/10 were negative. Midline chest wound culture is positive for Candida parapsilosis. Infectious disease was consulted, and the patient is now on IV Fluconazole for the same. WOC nursing consulted for wound care. The patient was seen with the provider for multiple full-thickness pressure injuries, sternal wounds, and scrotum, and penis ischemic wounds. Recommended NPWT dressing for the sternal wound. Patient alert and responding to commands. Spouse at bedside. The patient is agreeable to assessment and treatment. The patient received IV pain medication given by the primary RN. Head-to-toe assessment performed. The patient is on an Isolibrium mattress. The wound (chronic wound post op)on the left groin looked red and moist. The peri-wound was clean, dry, and intact. A small amount of old drainage was noted on the existing dressing. Wound measured 2.1 cm x 3.4cmx0.3cm. Wound bed was moist, 20%slough present. The wound was cleansed with a cleansing solution (Vashe). Silver alginate (Silvercel) with Foam (silicone foam with border) dressing was applied to the wound. The wound on the penis and bilateral thighs were open to the air. On assessment, the Right thigh wound measured 4x 6.1, and the Left thigh measured 5.2cm x 3.4cm, necrotic and with black eschar (calciphylaxis vs pressor response). The wound was cleansed with a cleansing solution (normal saline) and painted with Betadine. Moisture-associated wound over the scrotum, on assessment, looked pink and moist. Peri wound was fragile and denuded. Scant serous drainage was noted from the wound. The wound was cleansed with a cleansing solution (Vashe). Applied zinc oxide-based hydrophilic paste (Triad). The incisional wound on the Left BKA site looked clean, dry, and intact, and sutures (staples) were present. The peri wound looked pink and dry. No dressing was applied. Elevation of the stump is recommended.	ANIONGAP 10 BUNCRRATIO 4.8 MG 1.7 PHOS 2.2 ALB 2.0 ALT <6 AST 12 TBIL 0.5 DBIL 0.3 WBC 13.71 HGB 10.7 HCT 32.6 PLT 214 PTT 36.4 INR 1.3

On assessment, there was an unstageable pressure injury over the left proximal popliteal region, with slough, pink, and dry. The peri wound was clean and dry. Scant serous drainage noted. Wound measured 3cmx2.1cmx0.1cm. Cleansed the wound with a cleansing solution (Vashe). Applied skin barrier (Cavilon no sting) to the peri-wound, thin layer of hydrogel (Intrasite gel) to the wound bed, and covered with foam dressing (Silicone foam bordered). Unstageable pressure injury over bilateral buttocks sacrum extending towards left thigh was with slough and with scant drainage. A rectal tube was placed for profound diarrhea. Wound measured 15 cm x 12.1 cm x.2 cm. Cleansed the wound with a cleansing solution (Vashe). Applied Skin barrier (Cavilon no sting) to the peri-wound. Medi honey topical paste was applied to the wound bed. Foam dressing was applied (silicone foam sacrum) to cover the wound. Gently removed the old dressing over the sternal wound. On assessment noticed subcutaneous tissue, slough, hardware, and tenderness. It was decided to apply NPWT for better wound healing and got orders. Notified the Cardiothoracic team regarding the visibility of hardware. The wound measured 22.6 cm x 6.8 cm x 2.3 cm. Cleansed with cleansing solution (Vashe) and patted dry with gauze. Cavilon skin barrier and VAC drape were applied to the peri-wound for protection.3 pieces of contact layer (Adaptic touch) were placed on the wound bed.1 piece of black granufoam was spiraled and inserted into the wound bed.VAC drape was applied over the black foam, and a dime-sized window was cut to apply the trackpad. The trac pad was applied to the foam.NPWT was applied at 125 mmHg continuously as per the orders. A good seal was achieved. The outer dressing is labeled with the date, initials, and number/type of foam used. Patient was intolerant to pain. The primary provider ordered an extra dose of IV pain medication and was administered during NPWT application by primary nurse. Patient was repositioned comfortable, with lower extremities elevated over 2 pillows. Requested primary RN to apply heel off loading device for right leg. Dietician consult is in place. Encouraged patient and family regarding Oral feeding. Requested primary provider for surgery consult, for possible colostomy for fecal diversion for better healing of sacral wound.	ABG- 6/7/24 PHART 7.42 PCO2ART 45.9 PO2ART 142 BICARBONATE 23.0 BASEEXCESS -2 O2SATART 100 DEOXYHB <2.4 METHB <1.0 06/07/2024 OXYHB 98 06/07/2024 CARBOXYHB 1.4 Microbiology 6/10 BCx: ngtd x2 5/31 BCx: ngtd x2 5/31 Midline chest tissue culture site:

PT/OT request in place since admission and is visited as per routine. Current medications: • acetaminophen (TYLENOL) tablet DOSE: 650 mg q6h, prn, DHT • albuterol sulfate nebulizer solution DOSE: 2.5 mg • acetylcysteine (MUCOMYST) 20 % (200 mg/mL) inhalation solution DOSE: 200 mg • ascorbic acid (VITAMIN C) tablet DOSE: 500 mg, DAILY, DHT • atorvastatin (LIPITOR) tablet DOSE: 10 mg,daily, DHT • chlorhexidine (CHLORAPREP) 1 Applicator PRN, • cholecalciferol (Vitamin D3) 1,000 unit = 25 mcg tablet DOSE: 1,000 Units daily, DHT • darbepoetin alfa in polysorbate (ARANESP) injection DOSE: 60 mcg subcutaneous, once weekly • dextrose 10 % infusion IV prn • ferrous sulfate tablet DOSE: 325 mg, DAILY, DHT • fluconazole (DIFLUCAN) 40 mg/mL Oral Suspension DOSE: 200 mg, TWICE daily , DHT	Rare growth Candida parapsilosis

• fludrocortisone (FLORINEF) tablet DOSE: 0.1 mg daily, DHT • fluticasone propionate (FLONASE) nasal spray DOSE: 2 Spray • folic acid tablet DOSE: 1 mg, Daily, DHT • gabapentin (NEURONTIN) oral solution DOSE: 100 mg tds • glucagon (GLUCAGEN) injection DOSE: 0.5 mg IM prn • guaiFENesin (ROBITUSSIN CHEST CONGESTION) 100 mg/5 mL syrup DOSE: 200 mg twice daily • heparin lock flush injection DOSE: 300 Units tds • heparin lock flush injection DOSE: 500 Units prn • honey (MEDIHONEY) topical paste • HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL oral solution DOSE: 10 mL bd • HYDROmorphone (DILAUDID) injection DOSE: 0.25 mg q4h prn • insulin aspart (NOVOLOG) 1 unit/0.01 mL SUBCUTANEOUS • insulin aspart (NOVOLOG) 1 unit/0.01 mL SUBCUTANEOUS • lidocaine (LIDODERM) patch 5 %	

• lidocaine (PF) (XYLOCAINE MPF) injection 1% prn • magnesium sulfate in water IVPB DOSE: 2 g once • magnesium sulfate in water IVPB DOSE: 4 g once as per standing protocol • melatonin tablet DOSE: 9 mg hs, daily DHT • midodrine (PROAMATINE) tablet DOSE: 10 mg tds, DHT • modafiniL (PROVIGIL) tablet DOSE: 50 mg, Daily, DHT • norepinephrine (LEVOPHED) 8 mg/250 mL NS premixed infusion, IV gtt, • octreotide (SANDOSTATIN) 1,000 mcg in sodium chloride, 0.9 % 250 mL infusion IV gtt • ondansetron (ZOFRAN) injection DOSE: 4 mg, q6H, prn • pantoprazole (PROTONIX) injection DOSE: 40 mg, twice daily IV • potassium chloride (KAY CIEL) 20 mEq/15 mL oral solution DOSE: 40 mEq, daily DHT • potassium chloride ER (K-DUR) tablet DOSE: 40 mEq Daily, DHT • potassium chloride in water 20 mEq/100 mL infusion DOSE: 20 mEq, once, IV	

• povidone iodine (BETADINE) 10 % Topical Solution, DAILY • psyllium (METAMUCIL) powder packet DOSE: 1 Packet, Daily, DHT • sodium phosphate (mmol) 20 mmol in dextrose 5% (D5W) 256.67 mL infusion, IV, once • sodium thiosulfate 25% IVPB 25 g • thiamine mononitrate (VITAMIN B1) tablet DOSE: 300 mg, DAILY, DHT • white petrolatum-mineral oiL (STYE) 57.7-31.9 % eye ointment, prn	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Braden Score Sensory perception-slightly limited (3) Moisture- Very Moist (2) Activity- Bedfast (1) Mobility- Very limited (2) Nutrition- Probably inadequate (2) Friction and shear- Problem (1) **Total**-11- High risk for skin breakdown	Ensure pain is managed prior to wound care as per the medication orders from primary provider **1)** • Cleanse the wound with an antimicrobial solution (Vashe) • Apply barrier to peri-wound (Cavilon no sting) • Apply silver alginate (Silvercel) to the wound bed • Apply foam dressing (silicone foam	Wound exudate decreased and formation of granulation tissue. Peri wound is free from maceration/skin breakdown.	• Pain management is essential for better compliance of patient towards dressing changes and patient comfort • Vashe is a noncytotoxic antimicrobial solution that helps physically disrupt biofilm and remove microorganisms. • A barrier will help to protect the peri-wound, create a waterproof barrier

1)Wound -Left groin The peri-wound clean, dry, and intact. A small amount of old drainage was noted on the existing dressing slough. Wound bed is pink and with mild **2)Necrotic wounds on penis and B/L thighs** The wound on the penis and bilateral thighs is necrotic and with black eschar (calciphylaxis vs pressor response). Peri wounds intact **3) Moisture-associated wound over the scrotum** Wound bed pink and moist. Peri wound was fragile and denuded.	• Change alternate day and prn • Notify the wound care nurse if the wound worsening/not improving-increased exudate/non-viable tissue **Alternatives:Wound cleanser(normal saline), Hydrofera blue(slightly moistened), border foam** **2)** • Cleanse with normal saline and pat dry • Paint with Betadine daily and prn • Notify the wound care nurse if the wound worsening/not improving-if any drainage noted/lifting up of the eschar **Alternative**: **To cleanse with Vashe (hypochlorous solution)** **3)** • Cleanse the wound with a cleansing solution (Vashe). • Pat dry the wound bed with	The wound infection has been prevented. Prevented the worsening of the skin	between broken skin and the environment, and prevent further breakdown from moisture. • Silver alginate has antimicrobial effects and absorbs exudate and atraumatic to wounds. (R.B. Turnbull, Jr. MD, School of WOC Nursing Education, 2022) Necrotic eschar that are not open need not be covered with any dressing. Betadine solution helps to control and prevent infection by maintaining an antimicrobial environment over the wound surface. Betadine has a drying effect that can help desiccate the necrotic tissue, which can serve as a temporary barrier to infection. (R.B. Turnbull, Jr. MD, School of WOC Nursing Education, 2022)

Scant serous drainage was noted from the wound. 4**) The incisional wound on the Left BKA site** The wound is clean, dry, and intact, and the sutures (staples) are intact. The peri-wound looked pink and dry. **5)Unstageable pressure injury**	gauze • Apply zinc oxide-based hydrophilic paste (Triad). • Apply daily and prn • Avoid scrubbing the wound as this can irritate the skin more. • Use pH balanced wound cleanser (Coloplast bed-side care foam) or warm water to clean the wound by soaking a gauze with it to soften the cream before removal. • Notify the wound care nurse if the wound worsening/not improving **Alternative to Triad- Cavilon durable barrier cream** **4)** • Leave the wound open to air. • Elevation of the stump on pillow is recommended, to reduce swelling. • Notify the wound care nurse if changes noted- signs of infection/dehiscence	damage. Wound is healed form the moisture damage Wound infection/dehiscence prevented and no further pressure injuries noted over the stump.	• Triad forms a protective barrier on the skin to prevent moisture penetrating and causing skin damage, prevents maceration and excessive damage (R.B. Turnbull, Jr. MD, School of WOC Nursing Education, 2022)

over the left proximal popliteal region With slough, pink, and dry. Scant serous drainage peri-wound - clean and dry. **6)Unstageable pressure injury over bilateral buttocks sacrum extending towards the left thigh**	**5)** • Cleanse the wound with a cleansing solution (Vashe). • Apply skin barrier (Cavilon no sting) to the peri-wound, • Apply a thin layer of hydrogel (Intrasite gel) and cover with foam dressing (Silicone foam bordered). • Change dressing every other day and prn when saturated • Notify the wound care nurse if the wound worsening/not improving • Turn and reposition q2 hours and keep off pressure points to prevent worsening of existing pressure injury and development of new, using appropriate support devices **Alternative: Medihoney instead of Intrasite gel and foam dressing** **6)** • Maintain the rectal tube	Slough began to be peeled off and underlying layer visible. Peri wound protected from damage. Nurses' documentation indicate patient has been turned q2-3 hrs. Wound prevented from further contamination of stool.	Air exposure can increase the amount of oxygen that reaches the wound, which promotes cell proliferation and tissue repair. Hydrogel assist with autolytic debridement and supports the formation of granulation tissue and facilitates wound healing (Jaszarowski & Murphee, 2022) Position changing 2 hourly prevents worsening of existing pressure injury and formation of new.

Wound bed with slough scant drainage Peri wounds intact, clean and dry	(Flexi-seal) in situ as per the provider's orders and as per hospital policy and manufacturer recommendations. • Cleanse the wound with a cleansing solution (Vashe). • Apply Skin barrier (Cavilon no sting) to the peri-wound. • Apply Medi-honey topical paste to the wound bed (available from pharmacy- see medication orders in EMR) • Apply foam dressing (silicone foam sacrum) as secondary dressing • Change dressing every other day and prn when saturated • Turn and reposition q2 improving hours and keep off pressure points to prevent worsening of existing pressure injury and development of new, using appropriate support devices • Decrease friction and shear and place HOB at 30 degrees. • Notify wound care nurse	Peri wound is free from injury Slough from the wound bed peeled off and underlying layer visible Nurses' notes indicate, patient has been turned q2-3 hrs. and positioned at 30-degree angle.	Medihoney promotes autolytic debridement of the slough and prepare wound bed for wound healing. The antibacterial property assists in reducing bacterial load in the wound bed, preventing infection and promotes healing. Foam dressing acts as a cushion and retains adequate moisture for the wound for optimal healing. (R.B. Turnbull, Jr. MD, School of WOC Nursing Education, 2022)

	for any concerns/worsening of wound **Alternative: Intrasite gel(hydrogel) and foam dressing**		
7)Sternal dehisced surgical wound subcutaneous tissue, slough, hardware, and tenderness noted. Mild to moderate exudate Peri wound intact, clean and dry	7) -Gently remove the previous dressing -Cleanse with cleansing solution (Vashe) and pat dry with gauze. -Apply skin barrier (Cavilon skin barrier and VAC drape to the peri-wound for protection. -Place the contact layer (Adaptic touch) on the wound bed. -Insert 1 piece of black granufoam (spiral and insert) into the wound bed. -Apply VAC drape over the black foam, and a dime-sized window to be cut to apply the trackpad. Apply	Wound exudate reduced. Wound bed granulated Size of wound getting smaller Peri wound remained intact	Contact layer protects peri wound from skin breakdown from the black foam NPWT dressing promote granulation tissue formation and perfusion, removes exudate and infectious debris and prepares the wound bed for closure. (R.B. Turnbull, Jr. MD, School of WOC Nursing Education, 2021)

	the trac pad to the window and secure it. Apply the NPWT at 125 mm Hg as per the provider order. -Make sure a good seal is achieved. Label the outer dressing with the date, number/ type of foam used, and the number of contact layers applied. Frequency of dressing change- Monday, Wednesday, Friday by WOC nurse as mentioned above. *Nursing NPWT Care instructions*: • Monitor seal and VAC pump function • Assure the machine is plugged in, especially when returning to room after being off the floor • Change canister before full to avoid blockage • Check the seal and troubleshoot: reinforce using VAC drape only. Trim the excess lifted drape, cleanse area, and pat dry; apply new strip to drape the seal • If unable to rectify issues within 2 hours, the RN		

	should take down the NPWT dressing. Notify the physician. Page the wound care nurse(during office hours). Remove all foam and contact layers; Document how many pieces were removed; Irrigate the wound with normal saline; Pat dry with gauze. Apply a hydro fiber dressing (Kerracel), cover with an ABD pad, and secure with Medi pore tape; Change daily and prn when saturated until the NPWT is reapplied. (**Alternative to NPWT)** • Follow the dietician's recommendation for tube feeding and po diet. • Monitor blood sugar and treat as per the physician's orders for diabetes management • Patient to be placed on appropriate support surface (Isolibrium bed- Stryker)) • Offload the right lower extremity with heel offloading device(True Vue) **Alternative: Arjo Atmos air**		Appropriate nutritional intake is essential for tissue regeneration and wound healing. Optimal blood glucose control is essential for wound healing.

	low air loss mattress, Molnlycke Z-Flex fluidized heel boot		Appropriate support surfaces are essential for microclimate control and enhanced circulation (Mackey & Watts, 2022)

References:

Jaszarowski, K. & Murphee, 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. 157-168). 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. 425-443). Wolters-Kluwer

R.B. Turnbull, Jr. MD School of WOC Nursing Education. (2021). *Advanced Wound Therapy* [PowerPoint slides]

R.B. Turnbull, Jr. MD School of WOC Nursing Education. (2022). *Debridement Methods [*PowerPoint slides]

R.B. Turnbull, Jr. MD School of WOC Nursing Education. (2022). *Topical Therapy-Part 1* [PowerPoint slides]

R.B. Turnbull, Jr. MD School of WOC Nursing Education. (2022). *Topical Therapy-Part 2* [PowerPoint slides]

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: _____