WOC Complex Plan of Care

Name: Cristy Marie Ray **Date:** 6/21/2024

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
MT is a 50 year old male with history of cirrhosis, covid, gastrointestinal hemorrhage, anemia, encephalopathy, aortic stenosis, bowel and bladder incontinence, kidney stone, affective psychosis, TBI, seizures, left buttock stage 4 pressure injury, and obsessive compulsive disorder. Past surgical history includes ureteral stent placement, nephrostomy catheter, PEG tube placement, and thoracentesis. The patient also had a history of seizure-like activity which started in December 2023 with episodes of eye rolling back in his head, eyelids and head shaking, followed by confusion. In March 2024, he had full body convulsions and was started on Levetiracetam. While on Levetiracetam, he developed side effects such as irritability, anger, and thoughts of self-harm. Levetiracetam was replaced with Clobazam. Since Clobazam, the patient's family had noticed increased sleepiness, paranoia, auditory and visual hallucinations, rage outbursts, and meaningless speech with the patient. The patient was admitted to the epilepsy monitoring unit for diagnosis of events, seizure burden assessment, and psychiatric assessment. MT is being seen by the wound care team under the request of the provider to evaluate his stage 4 pressure injury on the left buttock. The patient has been known to the wound care team from previous admissions and has had the pressure injury since November 2023. The patient is lying in bed, in a supine position, attached to VEEG monitoring. He is alert but not responsive to simple commands except for eye contact. No acute distress noted. Telemetry and continuous pulse ox	3/11/2024 EEG: Suggests evidence of a moderate diffuse encephalopathy. No epileptiform discharges or EEG seizures were seen during this recording. MRI Brain wo contrast: Study somewhat degraded by motion artifact. No evidence of acute infarct or hemorrhage. No intracranial mass lesion. Moderate generalized brain parenchymal volume loss noted. 6/21/2024 WBC 3.93 HGB 10.9 HCT 34.1 Platelets 108

monitoring are also connected. Normocephalic, atraumatic. Moist mucus membrane. No movement of extremities noted. Foot drop observed to bilateral feet and arms appear contracted. Abdomen soft, non-tender. G-tube site at LUQ without inflammation or redness. Skin assessed with staff RN. As the patient was turned to their side, a moderate amount of unformed stool and yellow urine were noted. Pericare provided. Removed previous Alleyvn foam dressing to left buttock stage 4 pressure injury wound. The pressure injury was noted to be a full thickness wound. The wound bed appears red. Periwound displayed blanchable erythema, rash. Wound measurements are 4 cm (length) by 2 cm (width) by 4 cm (depth), with 3.5 cm of undermining at 2 o'clock. Small amounts of serosanguineous drainage with no odor noted. The wound was cleansed with normal saline and lightly patted dry with gauze. Vashe moistened (Kerlex) gauze roll lightly packed into the wound bed, then covered with a new Alleyvn foam dressing. ←*is this EBP? Vashe is approved by the FDA as a wound cleanser, not a soak (as far as I know). Make sure you are protected in your practice*. The patient moaned and displayed facial grimacing which likely indicates that he was experiencing pain during wound care. While pericare was provided, it was noted that the patient had incontinence associated dermatitis related to dual incontinence (of urine and stool) with a fungal component to the bilateral buttocks. The satellite lesions displayed blanchable erythema with an irregular shape. Maceration with peeling skin was also noted. Periwound was intact. Scant serosanguineous drainage noted. Antifungal cream (Baza) was applied to the affected areas. Photos on the wounds were taken to optimize the patient's medical care and allowed a visual aid to evaluate the wounds. The staff RN was informed on plans to place orders on skin care and preventive measures such as a heal protector boot and Comfort Glide with turning wedges to assist with repositioning as they were not present in the patient's room. Reeducated the staff RN to maintain single layer linens and single use disposable underpads while in bed. *– what surface was the patient on? This is important to note (and the function of such) with a stage 4 wound.* No known allergies. Current Medications: Lovenox 40 mg SQ q24hr Ativan 2 mg IV q5min prn Versed 5 mg IM q24h prn Pepcid 20 mg PEG daily Cyanocobalamin 500 mcg PEG daily	Albumin 2.8 Alkaline Phosphatase 216 AST 112 ALT 183 Glucose 96 BUN 22 Creatinine 0.61 Sodium 138 Potassium 4.4 Chloride 102 CO2 25 PT/PTT not drawn Prealbumin not drawn HgbA1C not obtained

Thiamine 100 mg PEG TID Sertraline 50 mg PEG Daily Rifaximin 550 mg PEG BID Miconazole 2% Topical BID Clobazam 10 mg PEG q12h Ibuprofen 600 mg PEG q8h prn Potassium 40 meq per feeding tube q 2 hr and prn Magnesiuim Sulfate 4-6 g IV prn Sodium phosphate 45 mmol IV prn Dextrose 50% 12.5-25 g IV prn Vancomycin 2 gm IV q 24 hr Meropenem 500 mg IV BID Sodium Thiosulfaate 25 g IV q 24 hr Pantoprozole 40 mg per feeding tube q 24 hours Chlorhexidine Rinse 15 ml orally with suction q 6 hrs IV GTTS: NaCI 0.9% 20 mL IV PRN Diet: Tube feeding Free water flush	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Left Buttock Stage 4 Pressure Injury -Full thickness wound -Wound bed: Red -Periwound: Blanchable erythema, rash -Wound measurements are 4 cm (length) by 2 cm (width) by 4 cm (depth), with 3.5 cm of	**Wound Care: Left Buttock Stage 4 Pressure Injury** 1) Remove old dressing, cleanse wound with normal saline and dry gently. 2) Apply 3M Cavilon Skin Barrier to periwound. Allow it to dry.	**Left Buttock Stage 4 Pressure Injury** -Decreased in nonviable tissue via wound debridement -Decreased in wound size -Decreased in wound exudate ✓ **Bilateral Buttocks Incontinence Associated Dermatitis**	**Wound Care: Left Buttock Stage 4 Pressure Injury** Normal saline is used in cleaning wounds because it is not cytotoxic to healthy tissues, and it will not traumatize a wound that is trying to heal (Ayello et. al, 2020). Normal saline can clean pressure

undermining at 2 o'clock -Drainage: Serosanguineous; small amount -Odor: None ✓ **Bilateral Buttocks Incontinence Associated Dermatitis** -Related to dual incontinence with a fungal component -Satellite lesions with irregular shape -Wound bed: Blanchable erythema and maceration with peeling skin. -Periwound: Intact. -Drainage: Scant serosanguineous -Odor: None **Braden Score: 9**✓ <u>Sensory:</u> (2) Very limited -Responds to painful stimuli -Unable to communicate discomfort except by facial grimacing and moaning <u>Moisture:</u> (1) Constantly moist -Fecal and urine incontinence <u>Activity:</u> (1) Bedfast -Confined to bed <u>Mobility</u>: (1) Completely limited	3) Lightly pack and fill wound bed starting with the area of undermining at 2 o'clock with fluff Vashe solution moistened gauze (Kerlex) roll dressing. *← see my above comment.* 4) Cover with Alleyvn foam dressing. 5) Change dressings BID and as needed. *6) Alternative* *Attach a 19-gauge needle to a 35-mL syringe and gently flush the wound with Vashe solution. solution. Then lightly pack sterile saline moistened gauze dressings to conform the wound bed, followed by a cover dressing like Alleyvn foam. Dressing change q8hours. <- this is EBP use of Vashe, but not gauze dressing. Gauze dressings are rarely indicated with changing practice. Consider a hydrogel layer if using gauze, or an alternative.*	-Resolved fungal rash -Resolved peeling skin -Wound edges no longer macerated from moisture ✓ **Skin Care/Surface Support** -Nurses' notes indicate patient being turned every 2 hours -Nurses' notes indicate Tru Vue boots in place ✓ **Pain** -Pain is tolerable during wound care *What is "tolerable"? make <u>sure</u> this is qualified using a universal scale.* **Diet** -Adequate weight- *what is goal? Was it met?* -Adequate fluid intake- *operationalize this. What is "adequate"? Was this met? What is observed?* -Electrolyte levels are within normal parameters -H&H and albumin levels are within normal parameters **Urinary & Fecal Incontinence** -Soft formed stools -Nurse's notes indicate use of collection devices for urine and/or stool incontinence✓ **Infection Control**	injuries by removing devitalized tissue and reducing bacterial burden (Ayello et. al, 2020). Using skin barrier wipes like 3M Cavilon Skin Barrier or film forming liquid acrylates can help protect the periwound skin from excoriation, trauma, maceration, or dermatitis. Without protection, wound healing will be delayed, the wound may increase in size, and the patient can experience more pain (Woo & Sibbald, 2020). A wound with tunneling, undermining, and depth may require wick, filler, and secondary dressings (Jaszarowski & Murphree, 2022). Filler dressings are designed to go into the wound and conform to its to the contours (Jaszarowski & Murphree, 2022). Cover dressings are designed to cover the wound (Jaszarowski & Murphree, 2022). Wounds with depth will require a filler dressing and a cover dressing (Jaszarowski & Murphree, 2022).

-Does not makes slight changes in body or extremity <u>Nutrition:</u> (3) Adequate -Receives tube feeding <u>Friction/shear:</u> (1) Problem -Requires maximum assistance with moving **Pain**✓ -Facial grimacing and moaning during wound care **Diet**✓ -Tube Feeding -Free water flush **Urinary & Fecal Incontinence** ✓ -Clear yellow non odorous urine -Unformed loose stool	**Bilateral Buttocks Incontinence Associated Dermatitis** 1) Provide pericare as needed using cleansing foam and/or premoistened wipes. 2) Apply Coloplast Baza antifungal barrier cream to buttocks BID and as needed. Alternate application with zinc oxide moisture barrier. 3) Apply Zinc oxide (Desitin) moisture barrier BID and as needed. Alternate application with antifungal barrier cream. *4) Alternative: Instead of Desitin, apply dimethicone BID and as needed. Alternate application with antifungal barrier cream.* 5) *Alternative:* IF barrier creams/ointments are not available: *a. Apply antifungal*	-Nurses' notes indicate completed CHG baths -Vital signs are within normal parameters -Decreased in wound exudate or purulent drainage -Decreased in erythema and induration in the periwound ✓	Vashe is a noncytotoxic solution and is used to clean noninfected wounds. It is a hypochlorous aid solution that is naturally produced in the body. In addition, Vashe has antimicrobial effects (Jaszarowski & Murphree, 2022). Gauze is used for wound cleansing and as a wick, filler, or cover dressing (Jaszarowski & Murphree, 2022). Loosely woven gauze allows for wound exudate absorption (Jaszarowski & Murphree, 2022). Gauze is applied in wounds with depth to avoid premature closure (Jaszarowski & Murphree, 2022). Overfilling or tightly packing

	powder to denuded skin as needed. *or* *b) Apply ConvaTec Stomahesive powder onto damaged and denuded skin, dust excess powder and apply 3M Cavilon Skin Barrier as needed* 6) Re-consult wound care nurse if there are changes to the wounds, if wounds worsen, and when new wounds occur. ✓ **Skin Care/Surface Support** 1) Provide pericare using cleansing foam and/or premoistened wipes. 2) Apply Comfort Glide patient repositioning system with turning wedges to offload the left buttock and surrounding areas q 2 hours. a. Place wedges behind the back and behind thighs. 3) If there are no contraindications, place patient on a 30-degree lateral tilt position using pillows or wedges. 4) When lying supine, flex the patient's knees and lay it		wounds with a dressing can produce internal pressure and should be avoided as it can interfere with perfusion. It can also compromise fibroblast activity and granulation tissue development (Jaszarowski & Murphree, 2022). Foam dressing is used as a primary and secondary dressing to maintain a moist wound surface (Jaszarowski & Murphree, 2022). *Alternative* *A pressure of 4-15 psi is the intended goal to remove debris from wounds and to reduce damage of newly growing tissue. Using a 35 mL syringe attached to a 19-gauge needle will create a psi pressure of 8 psi. (Jaszarowski & Murphree, 2022).* *A sterile saline wet-to-moist gauze dressing is used to maintain a moist wound base. Saline is not cytotoxic (Jaszarowski & Murphree, 2022).* *Wet-to-moist gauze dressings must be changed frequently to avoid drying. (Jaszarowski & Murphree, 2022).- is this the best option though? Consider an alginate or*

	resting on a pillow. Position other pillows under the patient's arms. 5) During transfers/repositioning, use support devices such as lift sheets, low friction linens, sliding/turning sheets, manpower or mechanical lifters to avoid dragging the patient. 6) Use pillows or other support devices to separate bony prominences such as the knees and ankles. 7) Place patient on low air loss specialty bed. 8) Maintain Tru Vue heel protectors to off-load heel while in bed. 9) Limit the amount of linen and incontinence pads used under patient. *What bed should the patient be on? Make sure you direct this.* **Pain** 1) Assess and manage pain appropriately for comfort prior to wound care. 2) When appropriate provide analgesia 30-60 minutes prior to dressing change. 3) Discuss with the wound care		*hydrofiber alternative. See current evidence re:gauze (in course resources)* **Wound care: Bilateral Buttocks Incontinence Associated Dermatitis** Cleansers for incontinence are pH balanced and contain surfactants to reduce surface tension and friction. Cleansers include premoistened wipes and foam (Thayer & Nix, 2022). Antifungal cream is the first line treatment for candidiasis due to its barrier function (Thayer & Nix, 2022). *Alternative* *Antifungal powder helpful in reducing moisture if the affected area is wet (Thayer & Nix, 2022).* Zinc oxide-thickened petrolatum is a skin barrier used to repel irritants in exudate, urine, and other fluids (Baranoski et al., 2020). Zinc oxide-thickened petrolatum can protect the skin against mechanical damage, and it has anti-inflammatory and antioxidant properties (Baranoski et al., 2020).

	nurse options of cleansing solutions and dressings appropriate for the patient during wound care. **Diet** 1) Follow dietician's recommendations for parenteral feeding. 2) Recommend calorie intake is 30-35 kcal/kg/d. 3) Recommended protein intake is 1.25-1.5 g/kg. 4) Recommended fluid intake is 35 mL/kg. 5) Monitor for signs of dehydration such as unintended weight loss, dry skin and mucous membranes, raid pulse, decreased venous pressure, subnormal body temperature, low blood pressure, and altered sensation. a. Monitor lab results indicating dehydration such as elevated albumin, BUN, hemoglobin and/or hematocrit, BUN/creatinine ratio greater than 25.1, and increased serum osmolality, serum, sodium, urine		*Alternative* *Silicone based barrier ointments such as dimethicone are permeable to water vapor and evaporates perspiration and minimizes the risk of heat rash. Conformable to periwound area or area of at-risk skin. Easy to spread and feels less greasy on skin (Baranoski et. al., 2020)* *Dimethicone is a moisture barrier cream that is breathable for the skin. When applied, the cream will vanish into the epidermis rather than remaining on the skin. This property allows for visualization of the underlying surface. (Thayer & Nix, 2022).* *Alternative* *Applying ostomy powder onto damaged and denuded skin can help create a dry surface area. Applying skin barrier film following ostomy powder application will create a protective barrier or a waterproof coating on the skin (Thayer & Nix, 2022).* **Skin Care/Surface Support** Using prepackaged, premoistened,

	concentration, and/or urine specific gravity. 6) Monitor and record patient's weight daily. 7) Per order, monitor other biochemical data: a. Correct fluid and electrolyte deficiencies. b. Correct hemoglobin and hematocrit levels. c. Correct low albumin. 8) Monitor blood sugar and treat per ordered sliding scale. *Make sure there are associated actions with all direction to monitor.* **Incontinence** 1) Discuss with provider factors causing loose or watery stools and collect a stool specimen for screening when appropriate. 2) Consult with provider to manage loose stools such as bulk fiber supplements or antidiarrheal medications when appropriate. 3) Use male external collection devices for urine incontinence. 4) Limit or avoid use of body worn absorbent products (BWAP) such as disposable briefs. – *specifically, when should the be used?*		rinse free, disposable cleaning cloths as opposed to conventional bath basins and wash cloth will maintain skin health and reduce the risk of infection (Borchert, 2022). When turning and repositioning patients, the redistribution of pressure reduces the magnitude of pressure and shear forces as they can injury soft tissue (Brienza, Tescher, & Call, 2020). Repositioning schedules should take into consideration the condition of the patient and the type of support surface in use (Ayello et al., 2020). *What was this?* Bedridden patients should be turned and repositioned at least every 2 hours as the goal is to relieve pressure on one part of the body and redistribute pressure to another body part (Borchert, 2022). The head of bed elevation should be as low as possible-at or below 30 degrees to decrease soft tissue deformity (Borchert, 2022).

	a. When using disposable briefs, check positioning and placement of the absorbent product. 5) Use a fecal pouch to contain stool incontinence. If not contraindicated, a fecal management system (FMS) can be utilized. ✓ **Infection Control** 1) If there are no contraindications, provide patient with daily CHG baths. 2) Report abnormal vital signs: low blood pressure, increased heart rate, and temperature 100.4 or greater. 3) Report worsening wound appearance, color, odor, drainage, excess bleeding, increased or new pain, increased heat palpated around the wound, redness spreading around the wound, swelling around the wound. ***✓ - make sure to stay WOC focused. No need to direct regular nursing duty.*** *Consider PT/OT for this patient. They have very poor mobility it*		When there are no contraindications, using the 30-degree lateral position for patients in bed will make turning easier and may also prevent shearing injuries (Ayello et al., 2020). 30-degree lateral tilt position by using pillows or wedges to maintain position can protect the trochanter and sacrococcygeal area (Borchert, 2022). To prevent/reduce the patient from sliding down, flex their knees and lay it resting on a pillow. Position other pillows under the patient's arms. This will reduce shear injuries (Borchert, 2022). During transfers or position changes, do not drag the patient as it may cause friction injuries to skin and shear injuries to deeper tissues (Ayello et al., 2020). Lift sheets, low friction linens (bedding and gowns), and manpower or electronic lift system should be used to transfer and reposition patients to reduce injury from shearing forces (Borchert, 2022).

	appears.		The separation of opposed bony prominences such as the knees and ankles with a pillow is recommended to protect the area from injury (Borchert, 2022). Heels are the second most common site for PI development (Borchert, 2022). Use of an off-loading boot should be considered if the patient has a prolonged bed rest restriction (Borchert, 2022). A support surface with low air loss features delivers a flow of air that will manage the heat and humidity of the skin. It works by use of air-filled compartments which is inflated by specific pressures based on the patient's height, weight, and distribution of body to provide loading resistance (Brienza, Tescher, & Call, 2020). Limiting the amount of linen and incontinence pads placed under a patient sitting/lying on the support surface/bed may make a difference in pressure injury incidence. (Ayello et al., 2020). **Pain**

			Determining the risk for intense pain during wound care procedures will provide the wound care nurse with the need for aggressive and early pain control management (Bates-Jensen, 2022). Wound care nurses need to ensure pain is managed and that the time for breakthrough medications will be effective against the pain experienced at dressing change (Woo & Sibbald, 2020). Choosing the appropriate cleansing solutions, debridement methods, and dressing needs will help decrease wound surface pain and trauma at the time of wound care and dressing change (Woo & Sibbald, 2020). *Make sure a scale is used for non-verbal patients – consider your documentations and actions from a legal review standpoint.* **Diet** Parental feeding can help patients maintain a positive nitrogen balance of which the body sustains the same amount of protein in its tissues every day based on the patient's goals of care (Posthauer, Dorner, & Chu, 2020).

			Calories help supply energy, prevent weight loss, and preserve lean body mass (Posthauer, Dorner, & Chu, 2020). For patients with a pressure injury, the recommended calorie intake is 30-35 kcal/kg/d (Posthauer, Dorner, & Chu, 2020). Protein is essential for wound healing as it supplies the binding material of skin, cartilage, and muscle. For patients with a pressure injury, the recommended protein is 1.25-1.5 g/kg (Posthauer, Dorner, & Chu, 2020). Recommended fluid needs for patients with infection and draining wounds is 35 mL/kg to replace lost fluid (Posthauer, Dorner, & Chu, 2020). Patients with wounds require adequate hydration as it aids in hydration of wound sites and in oxygen perfusion. Inadequate hydration may place the patient at risk for dehydration. Monitoring the patient's weight is one way to monitor for dehydration (Posthauer, Dorner, & Chu, 2020).

			Biochemical data are evaluated as part of the nutrition assessment and wound healing process. (Posthauer, Dorner, & Chu, 2020). Low hemoglobin and hematocrit can have a negative influence on wound healing. A low number of red blood cells will reduce oxygen-carrying capacity and decrease the body's immune function (Posthauer, Dorner, & Chu, 2020). Low serum protein levels may indicate the patient's risk for malnutrition eventually impaired skin integrity (Posthauer, Dorner, & Chu, 2020). Albumin is a type of protein stimulated by the inflammatory process due to infection, trauma, surgery, autoimmune processes, burns, etc. (Posthauer, Dorner, & Chu, 2020). Glucose levels are one way to check the patient's ability to tolerate the amount of protein recommended for wound healing (Posthauer, Dorner, & Chu, 2020). **Incontinence**

			Assessment of patients with fecal incontinence will allow wound care nurses to have a management plan individualized for the patient (Callan & Francis, 2022). Male external collection devices help to contain urine incontinence and keep skin clean (Baranoski et al., 2020). BWAP should be limited in use as it can trap moisture and increase heat at the product-skin interface (Thayer & Nix, 2022). A brief that is not positioned on the patient or fastened can move and bunch therefore, placing the patient at risk for friction or pressure injury (Thayer & Nix, 2022). A fecal pouch applied to the perianal area can be an alternative to fecal management system (FMS) (Thayer & Nix, 2022). – *seems like a great option in this case.* FMS are used for diversion of liquid stool in non-ambulant patients. It provides skin health and infection control (Thayer &

			Nix, 2022). Contraindications to use FMS on patients with clotting disorders, sensitive to any part of the FMS device, rectal/anal injury, rectal or lower large bowel surgery in the last year, and rectal mucosa impairment (Callan & Francis, 2022). **Infection Control** Daily bathing with cleansing wipes that contain chlorhexidine gluconate (CHG) can reduce the risk of infection (Borchert, 2022). A thorough assessment of wound characteristics is important in monitoring infection (Bates-Jensen, 2022). Wound inspection involves observing the wound for signs of complications like infection (Bates-Jensen, 2022). Inspecting the wound for infection includes increased wound exudate or purulent drainage, a need for more dressing changes due to increased volume of drainage, the periwound displays erythema and induration, the wound has a foul odor, and the patient has an

			elevated (Bates-Jensen, 2022). Chronic wound infection will display a delay in healing or a deterioration even with treatment. The wound bed may appear pale or dark red and friable granulation tissue, along with pocketing or tunneling at the wound base, and foul odor (Bates-Jensen, 2022). Chronic wounds are contaminated with microorganisms and may contain high levels of bacteria that may form biofilm that will impair healing. Therefore, repeated debridement and/or antimicrobial dressings may be needed in treatment (Bates-Jensen, 2022). ✓

References:

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Don't forget hanging indent with APA formatting

WOC Complex Plan of Care

Content		Possible Points	Awarded Points	Comments
Summary of Selected Patient	Summarizes pertinent medical and surgical history	*2*	*2*	
Assessment	Describe assessment findings	*6*	*6*	
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	*6*	*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*	*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*	*9*	*See my comments throughout – make sure support surface is identified and ancillary resources are thoroughly coordinated.*
	Propose alternative products. Include generic & brand names	*4*	*3*	*See comment re: EBP*
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	*6*	*4*	*See my comments*
Rationale	Explain the rationale for identified interventions	*6*	*6*	
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	*1*	*1*	
	Proper grammar & punctuation used	*1*	*1*	
	References: See the course syllabus for specific requirements on references for all assignments	*1*	*1*	
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50	*44/50*		

Additional comments:

Hi Cristy – this submission is on track and the organization of such illustrates your growth in your role. Continue to consider your actions from a legal review standpoint – make sure your practice is defensible with both your own documentation and the most recent evidence/approvals for products and interventions. Reach out with any further questions. You have reached the 80% satisfactory threshold on this assignment and no further work is needed on it!

WOC Complex Plan of Care

Reviewed by: _____Mike Klements 7/5/24_____ Date: ___7/5/24