WOC Complex Plan of Care

Name: ___Cristy Marie Ray_____ Date: _6/18/2024_____

Clinical Focus: Wound ____ Ostomy _X___ 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
G.M. is a 66 year old female with rectosigmoid adenocarcinoma and metastasis to the bladder, uterus, and right ureter, complicated by perforation requiring exploratory laparotomy, wash out, and a colostomy in October 2022. She then underwent 5 cycles of chemotherapy and a short course of radiation therapy. Other medical history includes BLE DVT, duodenal ulcer complicated by hemorrhage, hypotension, chemotherapy induced peripheral neuropathy, and anemia. Other surgical history includes cesarean delivery and EGD. She was admitted to the hospital for operative management. Patient underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy, cystectomy with ileal conduit on June 6/6/2024. ✓ Patient is being seen today by the ostomy team for routine pouch change to the colostomy ✓ and ileal conduit ✓ . The patient was lying in bed, resting comfortably. No acute distress noted. Patient was alert and oriented. Reported a dull, 2/10 pain to their abdominal midline incision. The patient reported feeling weak and tired. The patient also reported that appetite is getting better and eats a little over 50% of their meals. Denies nausea or vomiting. The patient reported that their spouse helps with pouch changes to their colostomy. The patient's spouse was present at bedside. The patient and spouse were asked about ostomy care lessons on the patient's new ileal conduit. The patient's	6/17/2024 WBC 15.22 Hgb 7.7 Hct 23.6 Platelet 569 Sodium 140 Potassium 4.5 Chloride 112 CO2 19 BUN 6 Creatinine 0.91 Glucose 80 Calcium 7.8 Magnesium 1.6 Phosphorus 3.3 Urine culture: + candida albicans

spouse reported that “I have watched it twice and I’m comfortable with changing the pouch. I’ve been changing her colostomy pouch for over a year now. They seem similar.” The patient and spouse declined to do the pouch change but agreed to observe the ostomy team with changing them. The patient’s abdominal midline incision was clean, dry, and intact with staples in place. No surrounding erythema or incisional drainage noted. Informed the patient and spouse that pouch change should start with the ileal conduit followed by pouch change to the colostomy to avoid the risk of infection and cross contamination of introducing stool to the ileal conduit. Patient and spouse verbalized understanding. Pouch #1: Ileal conduit Removed the worn Coloplast SenSura Mio soft convex urostomy and triangular Hollihesive washer with ConvaTec Esenta Sting Free Adhesive Remover wipes. The end ileal conduit was measured 1” and rounded out to the RLQ. The stoma protruded slightly but buds more with convexity. A portion of light green stent can be seen on the stoma. The mucosal condition and color were red and moist. The mucocutaneous junction was intact. Peristomal skin displayed erythema. The location of erythema was circumferential. The peristomal contour was slightly concaved. Supportive tissue was soft. Output is yellow urine with some mucus. The peristomal skin was cleaned with water-soaked wet gauze then patted with dry gauze. The ConvaTec Stomahesive powder was applied to the peristomal skin, followed by the application of the 3M Cavilon Skin Barrier wipes. A triangular Hollihesive washer is then applied to the peristomal skin, followed by the new Coloplast SenSura Mio Convex Light Urostomy Pouch with uro adaptor. The pouch’s uro adapter is then connected to gravity drainage. Expected wear time goal is 3-4 days. Pouch #2 Colostomy Removed the worn one-piece SenSura Mio cut to fit and Ceraplus barrier ring with ConvaTec Esenta Sting Free Adhesive Remover wipes. End descending colostomy was measured 1 3/8” rounded and sits oval at 1,” to the LLQ. The stoma was red, moist, and budded. The mucocutaneous junction was intact. Peristomal skin was clean and intact. Peristomal contour was rounded. Supportive tissue was soft. Output appears liquid green and brown. The peristomal skin was cleaned with water-soaked wet gauze then patted with dry gauze. The 3M Cavilon Skin Barrier wipe was applied to the peristomal skin and the Ceraplus barrier ring was stretched and then applied to fit directly to the skin before the skin barrier application. The new one-piece SenSura Mio Convex Soft cut to fit was then applied. Expected wear time goal is 3-4 days. The patient was given extra supplies for both pouch systems. The patient and spouse were instructed to	Height: 165 cm Weight: 83.5 kg BMI: 30.66 BP 107/68 Pulse 88 Temp 98.2 F (oral) Respiration 13 SpO2 97% room air

report any questions or concerns about ostomy care and pouch leakage. The patient and spouse verbalized understanding. Medications: Dextrose 15 g PO prn Glucagon 1 mg IM prn Dextrose 10% 12.5 g IV prn Zofran 4 mg IV q6h prn Fentanyl 25 mcg IV q2h prn Oxycodone IR 5-10 mg PO q4h prn Midodrine 10 mg PO q8h Gabapentin 100 mg QHS NaCl 0.9% 20mL IV prn Potassium chloride ER 20-40 mEq PO prn Potassium chloride 20 mEq IV prn Magnesium sulfate 2g IV PRN Phosphorus 500 mg PO prn Heparin 5,000 units SQ q12h Keflex 500 mg daily Dextrose 5% in NaCl 0.45% with 20 mEq/L KCl 0-80 mL/hr IV continuous Polyethylene glycol 17 g PO BID Protonix 40 mg daily Ferric gluconate 125 mg IV daily Insulin lispro SQ with meal and HS (per sliding scale) Zosyn 3.375 g IV q6h Simethicone 80 mg PO QID prn Diflucan 400 mg Daily Tylenol 1000 mg PO q6h	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Ileal Conduit -Stoma was 1” and rounded, located RLQ -The stoma is red and moist	**Pouch Change for Ileal Conduit** 1) Use CovaTec Esenta Sting Free Adhesive Remover wipes to gently release the worn pouch	-Erythema to peristomal skin of the ileal conduit has resolved - No peristomal skin problems	**Pouch System for Ileal Conduit** Skin barrier powder is made of hydrocolloid, and it helps absorb moisture. It can treat denuded

-The stoma protruded slightly out but buds more with convexity -A portion of light green stent can be seen on the stoma -Mucocutaneous junction was intact -Peristomal skin displayed erythema. The location of erythema is circumferential -The peristomal contour was slightly concaved -Supportive tissue was soft -Output is yellow urine with some mucus. ✓ **Colostomy** -Stoma was 1 3/8" rounded and sits oval 1" to the LLQ - The stoma was red, moist, and budded -The mucocutaneous junction was intact Peristomal skin was clean and intact -Peristomal contour was rounded -Supportive tissue was soft -Output appears liquid green and brown. ✓ **Diet** -Full liquid, tolerating small amounts; would like to try GIS foods -The patient reported that appetite	from the skin. 2) Clean peristomal skin: a. Wet gauze with water and gently wipe peristomal skin. b. Pat down peristomal skin with dry gauze. 3) Apply ConvaTec Stomahesive powder to denuded/irritated skin as needed with each pouch change until healed. a. Brush off loose powder from intact skin prior to pouching. 4) Apply 3M Cavilon Skin Barrier wipes to irritated skin as needed with each pouch change until healed. 5) Cut Hollihesive skin barrier to shape into a triangular washer and apply on peristomal skin. 6) Apply the new Coloplast SenSura Mio Convex Light Urostomy Pouch with uro adaptor. 7) Connect the uro adapter to gravity drainage. 8) Empty pouch when 1/3 full. 9) Avoid pulling on stents as they can migrate and become longer. 10) Expect mucus shreds in the urine. 11) Notify ostomy nurse if the stent lengthens or if there are	noted when pouch is changed to the colostomy -Pouch wear time will be 3-4 days for the ileal conduit -Patient and spouse will verbalized understanding of the presence of stents in the stoma -Patient and spouse verbalized understanding of mucus shreds in the urine -Pouch wear time will be 3-4 days for the colostomy -Stool output will be pasty to a semi form consistency -Patient will tolerate full liquid diet -Patient will advanced to a GIS diet -Nurses' notes will record patient's intake and output -Patient will have a minimal urine output of 800 mL in 24 hours -Nurses' notes will record meal percentage	peristomal skin. It should only be used on moist peristomal skin (Colwell & Hudson, 2022b). The application of the skin barrier powder followed by a liquid skin barrier film can enhance the seal of the powder (Colwell & Hudson, 2022b). Brushing off excess skin barrier powder on the skin will allow the skin barrier to seal (Colwell & Hudson, 2022b). Liquid skin barrier helps protect the skin from effluent or adhesive stripping. It keeps the surface of the skin dry and helps seal the skin barrier powder (Colwell & Hudson, 2022b). Skin barrier sheet helps protect the peristomal skin from effluent (Colwell & Hudson, 2022b). – *this patient has a colostomy – effluent is ileostomy output.* Choosing an extended wear skin barrier for an ileal conduit pouch system is recommended because of the continuous flow of urine (Stricker, Hocevar, & Shawki, 2022). *– great!*

is getting better and eats a little over 50% of their meals -Denies nausea or vomiting ✓ **Pain** -Reported pain to abdominal midline incision as dull with 2/10 pain scale -Denies pain from pouch change ✓ **Biochemical Data** -Sodium 140 -Calcium 7.8 -Magnesium 1.6 -Hbg: 7.7 -Hct: 23.6 -Reports feeling tired and weak ✓	concerns/questions to the stoma and pouch system. 12) Assess and change pouch system every 3-4 days and as needed for leaks. *13) Alternative: Use a skin barrier ring in place of the Hollihesive skin barrier on denuded skin.* ✓ ***consider a full alternative*** **Pouch Change for Colostomy** 1) Use CovaTec Esenta Sting Free Adhesive Remover wipes to gently release the worn pouch from the skin.- *make sure to do this change after the ileal conduit.* 2) Clean peristomal skin: a. Wet gauze with water and gently wipe peristomal skin. b. Pat down peristomal skin with dry gauze. 3) Apply 3M Cavilon Skin Barrier wipes as needed with each pouch change. 4) Stretch the Ceraplus barrier ring to fit around the stoma and apply directly to the skin before the skin barrier application. 5) Apply the new one-piece SenSura Mio Convex Soft cut to fit pouch system	-Patient will regain mobility and strength prior to discharge -Patient will sit up in chair with meals and will ambulate in the hallway -Patient will demonstrate ostomy care for their ileal conduit prior to discharge -Electrolyte levels will be in normal range -Hemoglobin and hematocrit levels will be in normal range *In general – avoid "will" statements. They have no place in medical records as they can't be guaranteed. The goal is to reach this status, or to promote the best environment for success. As nurses we know nothing is guaranteed, despite ideal conditions. We can only set patients up for success.*	Extended wear skin barriers have a low absorption property and stronger adhesions thus allowing for a longer wear time (Colwell & Hudson, 2022b). Choosing a convex skin barrier may enable the stoma to protrude above the skin barrier (Colwell & Hudson, 2022b). A convex skin barrier helps create a flat surface of the peristomal skin and enhances its seal (Colwell & Hudson, 2022b). A convex skin barrier can manage a pouch system from leaking especially when the effluent is liquid form (Colwell & Hudson, 2022b). Using a drainable pouch with an antireflex feature can prevent urine from refluxing and eroding the skin barrier seal (Colwell & Hudson, 2022b). Stents in an ileal conduit protect the ureter anastomosis, along with the healing process (Colwell & Hudson, 2022a). – *make sure directive in place to monitor and*

	6) Empty pouch when 1/3 full. 7) Notify ostomy nurse if there are concerns/questions to the stoma and pouch system. 8) Assess and change pouch system every 3-4 days and as needed for leaks. *Is there an alternative here for current pouching? Could this patient benefit from irrigation or a closed end pouch?* **Fluid/Diet/Medication Management** 1) Follow dietician's recommendations for full liquid diet and advance as tolerated. 2) Monitor blood sugar and treat per ordered sliding scale. 3) Monitor and record patient's weight daily. 4) Recommend fluid intake of 1,500-2,000 mL a day. 5) Recognize and report signs and symptoms of dehydration: increased thirst, lethargy, muscle cramps, dry mouth, abdominal cramps, dark urine, and decreased urine output. 6) Report for signs of UTI such as odor, discolored urine, back pain, fever, and chills. 7) If not on anticoagulants, drink/take unsweetened no additive cranberry juice or		*report if these are in place.* Mucus shreds noted in the urine are expected as the ileal conduit is made by the intestine. The mucosa from the intestine secretes mucus even when parts of the intestine are diverted. Volume of mucus will be high in the first few months after surgery but will eventually decrease with time (Colwell & Hudson, 2022a). *Alternative* *Instead of using a skin barrier sheet to protect the peristomal skin, a skin barrier ring can be used. It does not contain alcohol which will not sting the irritated skin. It also adds a second layer of skin barrier which will improve the seal (Colwell & Hudson, 2022b).* *The skin barrier ring also allows soft convexity (Colwell & Hudson, 2022b).* *Using a firm convex skin barrier may be another option to enhance proper seal of the skin barrier on a patient with a soft peristomal contour (Colwell & Hudson, 2022b).*

	capsule to keep urine acidic. 8) Avoid alkaline drinks such as orange juice and grapefruit juice. 9) Odor in urine can be produced by fish, broccoli, beer, asparagus, and antibiotics. 10) Beets and foods containing dye can change the color of urine. – *make sure to remain directive.* 11) Medications can also discolor urine: a. Cascara: black color b. Doxorubicin: red color c. Metronidazole: initially red and then turns to brown d. Sulfonamides: greenish-blue color – *what is the directive here? We can't change these orders.* 12) Once approved by provider and diet has advanced, consume foods like applesauce, bananas, boiled rice, creamy peanut butter, pectin supplement (fiber), tapioca, toast to help with watery stool output. 13) Discuss with provider to hold Polyethylene glycol as it may contribute to watery stools. 14) Discuss with the provider if there are other medications taking is causing watery stools.		**Pouch System for Colostomy** Choosing a cut-to-fit skin barrier allows for change and adjustment to the skin barrier opening as stomas can change and edema to the stoma subsides. This type of skin barrier can cut to the size of the stoma and to match its shape (Colwell & Hudson, 2022b). Oval shape skin barrier wafers can cover more area in the creases than a flat or round skin barrier wafer (Colwell & Hudson, 2022b). A skin barrier ring adds a second layer of skin barrier which will improve the seal (Colwell & Hudson, 2022b). *this promotes a better seal* The skin barrier ring can be used around an oval stoma when the pouching system that is used has a round opening. The ring can help cover any exposed skin not covered by the pouch system (Colwell & Hudson, 2022b). **Fluid/Diet/Medication Management** Urine should be acidic as alkaline

	15) Consult with provider for medications such as psyllium to bulk stool output or antidiarrheal medications when appropriate. *– is this directed, or is this completed by you?* **Pain** 1) Assess and manage pain appropriately and administer analgesics per order. **Biochemical Data** 1) Per order, monitor biochemical data via lab work: a. Correct fluid and electrolyte deficiencies b. Correct hemoglobin and hematocrit levels c. Monitor WBC counts *This is general nursing instruction – make sure to stay focused on WOC aspects of care.* **Emotional Support** 1) Consult with behavioral health for emotional support post ostomy placement, second ostomy, body image, and disease process. **Strength Management** 1) Consult with physical therapy for mobility and core exercises as patient reports weakness.		urine can form crystals on the stoma and peristomal skin leading to skin conditions such as pseudoverrucous lesions (Carmel & Scardillo, 2022). Maintaining adequate hydration and acidic urine can reduce and prevent UTIs and renal calculi (Carmel & Scardillo, 2022). *Operationalize all data for individual patients.* Unsweetened no additive cranberry juice or capsules/tablets can help make urine more acidic (Carmel & Scardillo, 2022). A colostomy patient having loose stools should first consider if this is caused by certain foods eaten, or is it caused by osmotic, mechanical, secretory, and/or pharmacological factors (Carmel & Scardillo, 2022). **Biochemical Data** Having an ileal conduit can alter the function of the patient's kidney and may lead to events like fluid and electrolyte imbalance, acid-base imbalance, urinary reflex, and renal failure (Ermer-Seltun, 2022).

	✓		**Pain** Managing the patient's pain will help determine their ability to participate in routine postoperative activities such as self-care ostomy management (Colwell & Hudson, 2022). **Emotional Support** Identifying and monitoring patients who have difficulty adjusting to their ostomy and other associated concerns can help meet their psychosocial needs (Carmel & Scardillo, 2022). **Strength Management** When medically cleared to perform physical activities, the patient may participate in gentle core and abdominal exercises to reduce the risk of peristomal hernias (Carmel & Goldberg, 2022). ✓

References:

Carmel, J., & Goldberg, M. (2022). Postoperative education for the patient with a fecal or urinary diversion. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., pp. 196-197). Wolters Kluwer.

Carmel, J., & Scardillo, J. (2022). Adaptations, rehabilitation, and long-term care management issues. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., pp. 206-211. Wolters Kluwer.

Colwell, J. & Hudson, K. (2022a). Postoperative nursing assessment and management. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., pp. 162-165). Wolters Kluwer.

Colwell, J., & Hudson, K. (2022b). Selection of pouching system. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., pp. 172-186). Wolters Kluwer.

Ermer-Seltun, J. (2022). Anatomy and physiology of the urinary system. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., p. 40). Wolters Kluwer.

Stricker, L., Hocevar, B., & Shawki, S. (2022). Fecal and urinary stoma construction. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., p. 139). Wolters Kluwer.

don't forget hanging indent. Page numbers should reflect the whole chapter.

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*	*n/a*	
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*	*10*	*See my comments*
	Propose alternative products. Include generic & brand names	*4*	*1*	*This is not done for majority of products.*
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*	*0.5*	
	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	*37.5/45*		

Additional comments:

Hi Cristy – see my comments throughout this complex case study – keep in mind that alternatives to pouching systems are needed for many reasons – including accessibility and cost for patients, as they are needed long term. Make sure you have a robust knowledge of brand alternatives as well as modifications as needed for patients. You have reached the 80% threshold on this assignment and no further work is needed on it! (Also see my comments re: "Will" statements – consider all writing from a legal review standpoint.

WOC Complex Plan of Care

Reviewed by: Mike Klements Received 7/5/24 Date: 7/5/24