WOC Complex Plan of Care

Name: __Cristy Marie Ray_____ Date: __6/20/2024_____

Clinical Focus: Wound ____ Ostomy ____ Continence _X___

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
J.D. is a 38 year old female with a history of anal fissure and hemorrhoids s/p anorectal exam under anesthesia, rigid proctoscopy, excision of 4th degree hemorrhoids in right posterior and left lateral positions in open technique with complete colonoscopy in March 2024. Her post operative period was complicated by several anorectal pain. In May 2024, a follow up exam was completed and showed healing hemorrhoidectomy sites. She then started on nifedipine ointment for pain control. ✓ Past Medical History: Anxiety, depression, GERD, constipation Past Surgical History: Hemorrhoidectomy The patient returns to the colorectal surgery clinic for continued anorectal pain. Patient was sitting on the chair, alert and oriented. No acute distress noted. The patient reported having anal spasms after each bowel movement. Reported that spasms also cause urinary hesitancy. Reports pain is better but not gone. Reported nifedipine ointment helps with minimal relief. Patient reported that she will have the urge to have a bowel movement but occasionally will have mucous or flatus. Patient reported occasional incontinence of stool. Unsure if she empties her bowels completely. Has daily bowel movement. Reported that stools are formed and sometimes hard. Take MiraLAX	Height: 165.1 cm Weight: 133.4 kg BMI 48.92 Digital Rectal Exam: Anus: Closed Resting tone: HIGH Squeeze tone: Normal Valsalva: Poor relaxation, some relaxation and lengthening Anorectal Manometry: High tone noted. No recent labs obtained.

and Dulcolax as needed. Patient reported strain at times. The patient admitted to not eating a well-balanced diet. Exercise twice a week with 30-minute walks. Patient verbal consented to digital rectal exam and anorectal manometry. Her perianal skin was intact. No erythema, induration or excoriation. No fissure, fistula, or external hemorrhoids noted. ✓ Medications: Tylenol Extra Strength 500 mg PO q6hrs prn Dulcolax PO daily Wellbutrin XL 300 mg PO daily Lexapro 10 mg PO daily Levonorgestrel Intrauterine Multivitamin PO daily Protonix 40 mg PO daily Miralax PO daily Compazine 10 mg PO q6hrs prn Nifedipine Topical q8h prn	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Digital Rectal Exam -Anus: Closed -Resting tone: HIGH -Squeeze tone: Normal -Valsalva: Poor relaxation, some relaxation and lengthening ✓ **Anorectal Manometry** -High tone detected **Rectal Pain** -Tolerated digital rectal exam; denies pain -Reported anal spasms occur after each bowel movement	**Bowel Diary** 1) Record bowel habits and stool description. **Pelvic Floor Physical Therapy (PFMT)** 1) Review pictures/models of the pelvic anatomy and verify periods of rest and contraction of the pelvic floor muscle. 2) Focus on the technique of the performance rather than the repetition of the performance.	Patient keeps note/diary of bowel habits and stool description -Patient demonstrates proper technique of PFMT -Patient reports minimal to tolerable anal spasms/pain -Stools are soft *-no signs of constipation?* -Patient tolerates high fiber diet	**Bowel Diary** A bowel diary consists of objective information reported by the patient regarding their elimination patterns. More reliable than verbal self-report. A bowel diary will help the continence nurses and providers in making proper diagnosis and developing individualized treatments (Callan & Francis, 2022). **Pelvic Floor Physical Therapy**

-Nifedipine ointment helps “a little” **Braden Score: 19** Sensory: 4 No impairment Moisture: 3 Occasionally moist -Occasionally incontinent Activity: 4 Walks frequently -Does not require assistance -Requires no mobility devices Mobility: 4 No limitations -Moves independently Nutrition: 4 Excellent -Not on any restricted diet Friction/shear: N/A ✓ **Constipation** -Occasional hard stools -Takes MiraLAX and Dulcolax as needed -Reported that absence of stool is replaced by mucus output or flatulence -Reported straining at times **Fluid Intake & Diet** -Drinks 4-6 glasses of water a day -Eats 1-3 servings of fruits and vegetables a day **Fecal Incontinence and Urgency**	3) Proper technique involves contracting the pubococcygeal muscle and not the abdominal, buttock, and inner thigh muscles. 4) Maintain a comfortable position by lying supine with knees bent and head on a pillow. a. For muscle isolation, squeeze as if you are refraining from passing gas. To do so, keep your abdomen, thighs and buttocks relaxed. b. Palpate the pelvic floor muscles and assess the use of accessory muscles (buttocks, abdomen, thighs). c. Start by squeezing for 5 seconds and relaxing for 5 seconds. d. Avoid Valsalva or holding your breath by counting out loud. e. Hold muscle contraction at 50% strength and gradually increase your strength as the muscle	-Patient keeps note of fluid intake -Patient exercises regularly *Is wt loss a goal?* *pt maintains continence?*	**(PFMT)** PFMT is an early intervention and a conservative management option used to help patients with rectal distention or who have difficulty retaining stool caused by weakened or damaged sphincter muscles (Callan & Francis, 2022). The proper technique of PFMT involves having the patient contract the pelvic floor muscles while keeping the abdominal muscles relaxed (Callan & Francis, 2022). ✓

-Occasional incontinence during urgency **Urinary Hesitancy** -Reported the inability to urinate during anal spasms **Physical Activity** -BMI: 48.92 *(!)- make sure wt loss is discussed.* -Reported starting to exercise. 30-minute walks twice a week. ✓	strengthens. f. When muscle strengthens, gradually increase to a maximum duration of 10 seconds and relaxing the muscles 10 seconds. 5) Repeat the squeeze and relax 10 times, at least 3-4 times a day. 6) If tolerable, place yourself in a sitting and standing position during pelvic floor muscle exercise (PME) training. 7) Record how long you can suppress the urge to void prior to using the toilet. ✓ **Pain** 1) Take Sitz baths prn. *2)* Take Baclofen 10 mg lidocaine 50 mg suppositories prn. *– per order* 3) Use nifedipine ointment TID. **Constipation** 1) Stay in a relaxed position when sitting on the toilet. 2) Correct position for opening bowels: a. Place your feet flat on		**Pain** Managing the patient's pain will help determine their ability to participate in treatment (Colwell & Hudson, 2022a). **Constipation** Correct positioning for opening of the bowels promotes healthy bowel habits. Also, it will normalize stool consistency and bowel emptying (Thompson, 2022).

	the footrest. b. Lean forward and put your elbows on your knees. c. Bulge out your abdomen and straighten your spine. d. Be sure your knees are elevated above your hips. 3) Another position for opening bowels is the modified squat position: a. Raise your knees above your hips when on the toilet with a footrest. This will allow straightening of the anorectal angle. 4) The best time of day for a bowel movement is about 30 minutes after the morning meal. 5) Refrain from straining. 6) Discuss with provider on constipation causing medications. 7) Avoid digital removal of bowels. *Consider diet to help with constipation risk.*		✓ A good time to have a bowel movement is 30 minutes after the morning meal because gastrocolic reflex is more active (Thompson, 2022). Refrain from straining during voiding to ensure relaxation of the pelvic floor muscle (Callan & Francis, 2022). ✓ Medications are a common contributing factor to constipation, and it includes anticholinergics, antihistamines, antispasmodics, tricyclic antidepressants, antipsychotics, and barbiturates (Callan & Francis, 2022). Digital removal of feces should be considered as a last resort and only after a complete bowel assessment due to pain, bleeding, rectal and anal tears, and bradycardia caused by vagal nerve stimulation (Kamp & Heitkemper, 2022). ✓ **Food Intake & Diet** Lifestyle modification is the first-line treatment for normal transit constipation which includes fluid, fiber, and

	Fluid Intake & Diet 1) Recommend a daily fluid intake of 1.5 to 2.5 liters. 2) Take a daily fiber intake of 25 grams. 3) Avoid or limit fluids such as alcohol or caffeine. 4) Limit intake of high-fat and processed foods. 5) Avoid or limit fast food. 6) Whole grains, fresh fruits and vegetables are choices of dietary fiber. 7) Include bulk forming fiber supplements (ie., psyllium and methyl cellulose) in your daily fiber intake. 8) Discuss with provider on the use of laxatives. ✓		exercise (Kamp & Heitkemper, 2022). Adequate hydration can prevent constipation and incontinence by ensuring a normalized stool consistency (Kamp & Heitkemper, 2022). Lifestyle modification also includes the eliminating or reducing medications that causes medications (Kamp & Heitkemper, 2022). Fiber helps with bowel function such as increasing moisture content and softening stool. Fiber also increases stool bulk and decreases colonic transit time (Kamp & Heitkemper, 2022). Alcohol and caffeine may cause dehydration and deplete the recommended fluid intake (Callan & Francis, 2022). High fat foods slow GI motility (Callan & Francis, 2022). The processing of fast food diminishes the benefit effects of dietary fiber (Callan & Francis,

			2022). Foods high in fiber add bulk to the stool to promote peristalsis. It also acts as a natural stool softening agent (Callan & Francis, 2022). Bulk forming fiber supplements work by absorbing water with hardened stool and eventually softening the stool. (Callan & Francis, 2022). Patients are encouraged to take fiber supplements daily and to titrate the dose to obtain appropriate stool consistency. Bulk forming fiber works best with adequate fluid intake (Callan & Francis, 2022). Laxatives are second-line interventions for normal transit constipation. It should be used on an as needed basis because it may adversely affect motility overtime (Kamp & Heitkemper, 2022) ✓

	Urinary Hesitancy 1) Apply pelvic floor muscle exercises – *how? Be specific as to when when giving this directive.* **Fecal Incontinence and Urgency** 1) Perform relaxation techniques such as deep breathing to also suppress the urge 2) Use a gauze or soft pad (insert) against the anus and held in place by the cheeks of the buttocks 3) Or use disposable absorbent products such as pull-on when traveling outside of home 4) Perform relaxation techniques such as deep breathing to suppress the urge 5) Record how long they can suppress the urge to void prior to using the toilet. **Physical Activity** 1) If there are no contraindications encourage regular exercises		**Fecal Incontinence & Urgency** Deep breathing techniques can help control urgency (Thompson, 2022). Use soft pads (inserts) or gauze for light fecal incontinence (Kent & Holderbaum, 2022). Use disposable briefs/pull-ons when there is moderate to heavy fecal incontinence (Kent & Holderbaum, 2022). **Physical Activity** Increased activity stimulates peristalsis. It also helps soften stool decreasing transit time (Kamp & Heitkemper, 2022) ✓

	consider wt loss goals and outside help – this patient has an abnormal BMI		

References:

Callan, L., & Francis, K. (2022). Fecal incontinence: Pathology, assessment, and management. In J.M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence Management* (2nd ed., pp. 485-513). 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.

Kamp, K., & Heitkemper, M. (2022). Motility disorders. In J.M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence Management* (2nd ed., pp. 455-477). Wolters Kluwer.

Kent, D., & Holderbaum, L. (2022). Appropriate use of absorbent products, containment devices, and adaptive aides. In J.M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence Management* (2nd ed., pp. 329-350). Wolters Kluwer.

Thompson, D. (2022). Management fundamentals for incontinence. In J.M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence Management* (2nd ed., pp. 84-104). Wolters Kluwer.

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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*	*5*	*Is this patient on any current management program of any conditions?*
	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*	*10*	*See notes*
	Propose alternative products. Include generic & brand names	*4*	*0*	*This is no noted*
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	*6*	*5*	*See notes*
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	*42/50*		

Additional comments:

Hi Cristy – see my notes throughout. Despite there not being a lot of products for a patient like this, consider alternatives to your instruction as well as when to follow up with providers. You have reached the 80% threshold on this assignment and no further work is needed on it! Reach out if you have any further questions! -Mike

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Reviewed by: ___Mike Klements received 7/5/24__ Date: __7/8/24