WOC Complex Plan of Care

Name: ___Tracy Leal_____ Date: __07/11/2024_____

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
This patient is a 44-year-old female referred to the colorectal clinic for manometry testing, rectal sensation testing, and EMG recruitment related to constipation. She has a PMH significant for Hypermobile Ehlers Danlos Syndrome (EDS), postural orthostatic tachycardia syndrome (POTS), obstructive sleep apnea (OSA), hypertension (HTN), anxiety, depression, gastroparesis, colonic inertia, pancreatitis, and bulimia nervosa. This patient also reports sexual abuse throughout childhood as well as a pelvic injury when bike riding as a child. She is unable to state what type of pelvic injury as she was very young. She also reports one suicide attempt resulting in a broken femur and pelvic fractures x3, though her chart reports multiple attempts made. Her past surgical history includes hysterectomy (8/2022), laparoscopic cholecystectomy (2012), J tube/PEG (2024), stenting and ablations in the pancreas (2013), C4-7 fusion (2015) with cervical laminotomy re-exploration with partial facetectomy/foraminotomy (2018). The patient has a pending urodynamic study related to urinary urgency and urinary incontinence. She is Gravida 0, Para 0. The patient reports marijuana use daily, has never smoked nicotine, and is not currently using alcohol. The patient is A+O x3 and in no apparent distress. She is well hydrated, but cachectic. The patient reports she had diarrhea while on IVIG treatment which was stopped “a few months ago”. When this was stopped and she received her G-J tube, she became constipated. She states, “It is one extreme or the other with me.” She reports her	• Colonoscopy (2024)- no abnormal findings • Smart pill (2020) – delayed gastric transit with delayed colonic transit. • Anorectal manometry (today) showed normal resting pressure (50 mm Hg) and weak squeeze pressure (61 mm Hg). There is minimal incremental change between resting and squeeze pressures which can indicate poor pelvic floor movement with squeeze. • Rectal sensation testing (today) shows a normal first sensation (43 mL), a normal first urge to defecate (100 mL), a normal maximum tolerable volume (150 mL), and a present recto-anal inhibitory reflex. The patient is unable to expel the balloon.

stool to be daily and loose with the use of Linzess, but sludge like and only 1-2 times weekly without Linzess. She reports mucous with stooling and accidental bowel leakage 1-2 times per week when on Linzess. She wears paper towels in her underwear "just in case". She does not use enemas or suppositories and reports no straining with bowel movements. She states she feels bloated and like she is not emptying completely. Patient reports pain with bowel movements that improves once she has gone. The patient sometimes takes Bentyl for intestinal spasms. Her perianal skin is intact, no excoriation, and free from erythema. No induration, no fluctuance, no heat. No fissures, external hemorrhoids, nor fistulas noted. Digital rectal exam performed by PA revealed normal resting tone, and weak squeeze tone. Upon Valsalva, pelvic floor relaxation is abnormal showing minimal movement, poor relaxation, and no paradox. Palpation of the puborectalis muscle is non-tender in the left anterior, right anterior, left posterior, and the right posterior. There is a large rectocele present with no rectal prolapse at anus. PA did not perform abdominal exam. With assessment and testing as stated above, this patient may have pelvic floor dyssynergia and poor pelvic floor movement contributing to constipation.	• EMG recruitment (today) shows a normal increase in activity with squeeze, and no change in activity with Valsalva. This indicates abnormal pelvic floor movement, which can be indicative of poor pelvic floor coordination.

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Constipation: "I feel like I am bloated." Bowel movements can be painful. I only go 1-2 times a week "if I am lucky" when taking Linzess.	1. Drink at least 8, 10 oz glasses of water daily 2. Continue with prescribed bowel regimen of alternating use of Amitiza and Linzess. 3. Osmotic laxative (Miralax) *alt: lactulose* 4. Pelvic floor muscle physical therapy (PFMT). 5. Follow up with Sitz marker test results as ordered by PA. 6. Follow up with defecography results as ordered by PA.	1. Patient will report drinking 8 or more glasses of water daily at follow up visit. 2. Patient will report use of bowel medications as prescribed and their effectiveness at follow up visit. 3. Patient will report appropriate use of laxatives as needed and their effectiveness at follow up appointment. 4. Patient will begin PFMT as ordered and discuss effectiveness, feelings about	1. Ensuring proper hydration helps to keep stools soft. The increase in fiber needed to treat constipation also requires a concurrent increase in fluid intake. Soluble fiber with water, adds bulk to the stool and acts as a mild laxative (Kamp & Heitkemper, 2022). 2. The patient reports worsened constipation without medications. This will need to be held, as prescribed by the PA, for the Sitz marker and defecography tests ordered. 3. This patient has slow transit

	7. Hygiene after any stooling. Use barrier cream for incontinence (Desitin) and one with CMC for raw or denuded skin (Critic-Aid). 8. Avoid a paper towel for incontinence. Use a BWAP such as an incontinence pad (DynaDry liners by North Shore) 9. Exercise 10. Use a “squatty potty” or step stool when defecating. 11. Nutrition consult with food/stool diary and followed by identified dietary changes. 12. Psychology consult for gut-brain hypnotherapy	the therapy, and willingness to continue at next follow up visit. 5. Follow up with Sitz marker test with PA to determine type of constipation and alter treatment plan as needed. 6. Follow up with defecography study results with PA and determine next steps in treatment. 7. Patients perineal skin with remain free from breakdown or irritation at next visit. 8. Patient will report type of BWAP, efficacy, and her comfort with wearing. 9. Patient will report walking 30 minutes daily. 10. Patient will report use of some kind of stool or aid to promote the ability to sit in the optimal position for defecation and if this is helping her completely evacuate her bowels as evidenced by her feeling less bloated or full. 11. Patient will have had a nutrition consult with a completed a food/stool diary and be able to state dietary recommendations and her	constipation which can require ongoing use of laxatives. Osmotic agents are considered safe for this (Kamp & Heitkemper, 2022). 4. PFM exercises help to strengthen the puborectalis muscle and anal sphincter tone (Thompson, D. L., 2022). This patient has poor pelvic floor movement with squeeze and would benefit from PFM physical therapy. 5. Per the ordering PA, this test is more sensitive than the Smart Pill test. Transit time studies determine the type of constipation, and the results will help guide treatment (Kamp & Heitkemper, 2022). 6. Defecography is indicated for functional evacuation problems, like rectocele (Lonergan Callan, F. & Francis, K., 2022) 7. Cleansing and protection after any episodes of incontinence are paramount for avoiding IAD and pressure injury prevention (Thayer, D. & Nix, D, 2022). 8. A paper towel is not absorbent enough and could cause a friction injury. This patient is ambulatory with light fecal incontinence and urinary incontinence “sometimes”. According to the

		willingness to make these changes or if not, any barriers. 12. Patient will report she has begun the agreed to gut-brain hypnotherapy, how she thinks this is helping her, and if she is willing to continue.	Body-Worn Absorbent Product Guide on the WOCN website, the patient would benefit from disposable-shaped pads with super absorbent polymers. 9. Regular moderate exercise is thought to help strengthen pelvic floor muscles and improve bowel motility (Thompson, D. L., 2022). 10. There is an optimal position for emptying the bowels completely. This includes knees higher than the hips, leaned forward with the elbows on the knees (Thompson, D. L., 2022). 11. A nutrition consult with a stool/food diary will help this patient identify foods that trigger unwanted changes in bowel habits, and hopefully help her get to a healthy body weight (Thompson, D. L., 2022). 12. According to Jayasinghe et al., (2023), CBT and gut-brain hypnotherapy have the greatest supportive evidence for long term benefits to bowel function.
Pain: Pain with bowel movements Abdominal spasms Anorectal pain sometimes after defecation	1. Tylenol or Ibuprofen for pain. 2. Take prescribed Baclofen as scheduled and Bentyl prn. 3. Apply lidocaine cream to	1. Patient will report an acceptable pain level at her follow up appointment. 2. Patient will report taking her medications as prescribed, effectiveness, and use of prn	6. OTC options for pain control are first line treatment for pelvic pain related to IBS (Hull, A., 2022) 7. Baclofen is indicated for

	the anus 4. Soak your anus in a Sitz bath for 20 minutes. 5. Non-pharmacologic methods for pain control like imagery, distraction, or meditation.	medication for spasms. 3. Patient will report acceptable pain level, or no irritated tissue, near her anus. 4. Patient will report if Sitz baths were necessary and if they were effective. 5. Patient will report modes of nonpharmacological pain control she has attempted, if she needs resources for help with this, and if she feels this has been effective.	muscle spasms and Bentyl is specifically indicated for relaxing stomach and bowel muscles, thereby reducing cramping. 3. Lidocaine is a topical ointment that can help with pain associated with skin irritation (Hull, A., 2022). 4. Warm water will improve blood flow and promote healing and pain relief in this area. These are recommended during flare ups (Hull, A., 2022). 5. In conjunction with pharmacological pain control, there is low risk to the addition of nonpharmacological interventions. There is evidence to support the mind-body connection with pain and the connection with stress, depression, and anxiety. (Deng, G., 2019)
Urinary Urgency/incontinence "I feel like I have to pee and then suddenly it is dripping down my leg"	1. PFMT 2. Use BWAP 3. Smoking cessation (pt vapes)	1. Patient will begin PFMT as ordered and discuss effectiveness, feelings about the therapy, and willingness to continue at next follow up visit. 2. Patient will report type of BWAP, efficacy, and her comfort with wearing. 3. Patient will report a	1. This is first line therapy for UI and urgency (Thompson, D.L., 2022) 2. The use of BWAP allows the patient to conceal their incontinence, avoid stigma, improve QOL, and help protect skin integrity when used appropriately (Kent, D.J. & Holderbaum, L., 2022). There is a

		decrease or stop in vaping, or request help with cessation as needed.	selection guide on the WOCN website as mentioned above. 3. The effects of vaping on bladder health are unknown, but smoking has significant risks to bladder, and overall, health and cessation should be encouraged in all healthcare settings (Thompson, D. L., 2022)
Braden Score: 20 <u>Sensory:</u> 4 No impairment - walked in unassisted <u>Moisture:</u> 2 Often moist -Fecal incontinence on medications, urinary urgency/incontinence <u>Activity:</u> 4 Walks frequently -declined BSC at this time <u>Mobility</u>: 4 -changes position independently <u>Nutrition:</u> 2 probably inadequate -reports poor intake, very thin, h/o eating disorder <u>Friction/shear:</u> 3 no apparent problem - Able to reposition safely on exam table while lifting up Age:44	Moisture- use of BWAP as listed above. Hygiene and barrier products as listed above. Nutrition: nutritional consult to help with stool consistency, bladder triggers for incontinence, as well as caloric deficit related to low BMI and po intake.	Patient will remain free from any skin breakdown. Patient will be able to verbalize risks to skin with prolonged exposure to moisture and/or pressure. Patient will be able to independently assess perianal/perineal skin for breakdown. Patient will be able to state the risks of poor nutrition to skin integrity and wound healing.	Cleansing and protection after any episodes of incontinence are paramount for avoiding IAD and pressure injury prevention (Thayer, D. & Nix, D, 2022). A nutritional consult will help the patient to identify bladder triggers for UI/urgency, help to get stool to a desired consistency, and assist patient with healthy food choices to get her to an optimal weight (Thompson, D. L., 2022).

References:

Jayasinghe, M., Damianos, J. A., Prathiraja, O., Oorloff, M. D., Nagalmulla K, G. M., Nadella, A., Caldera, D., & Mohtashim, A. (2023). Irritable bowel syndrome: Treating the gut and brain/mind at the same time. *Cureus*, *15*(8), e43404. https://doi.org/10.7759/cureus.43404

Deng G. (2019). Integrative medicine therapies for pain management in cancer patients. *Cancer Journal*, *25*(5), 343–348. https://doi.org/10.1097/PPO.0000000000000399

Kamp, K. & Heitkemper, M. (2022). Motility disorders. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy Management* (2nd ed., pp 454-483). Wolters Kluwer.

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Lonergan Callan, L. & Francis, K. (2022). Fecal incontinence: Pathology, 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 484-519). Wolters Kluwer.

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Wound, Ostomy, Continence Nurses Society ™ (WOCN ®) (n.d.). Body worn absorbent product guide. https://bwap.wocn.org/

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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: _____