WOC Complex Plan of Care

Name: _____Darleen Olsen_____ Date: _____7/19/2024_____

Clinical Focus: Wound • Ostomy ☒ Continence •

Number of Clinical Hours Today: __8.5__

One complex journal is required for *each* specialty in which you are enrolled. 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 enrolled 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
67-year-old female (BMI 25. 4) overweight with history of bowel perforation, hypokalemia, E. coli infection, and malnutrition mild degree. Patient denies alcohol, drug, tobacco, and smoking. Patient had a bowel perforation 6/23/2024 due to bowel impaction measuring 8-10 cm ball in the cecum and was hospitalized during this time frame. The bowel perforation was pinhole size and had pneumoperitoneum peritonitis complication. The patient had emergent stool evacuation with double barrel ostomy, end ileostomy and mucus fistula cecum. Surgical history significant for exploratory laparotomy, ileocecal resection with end ileostomy and mucous fistula on 6/23/2024 due to bowel perforation and pneumoperitoneum peritonitis. Patient readmitted for sigmoidoscopy a couple weeks ago. No other medical conditions per chart review. She is retired and currently in rehab facility and has support of her son and daughter-in-law. The patient was discharged from the hospital and is in rehab facility and comes to visit with Colorectal surgeon and WOC nurse for concerns of retracted stoma and mucocutaneous separation. The patient has Medicare insurance. The patient was not able to keep a pouch on or apply a pouch, neither were nursing at the facility. Patient had a towel over the area upon WOC student entering the room. Patient assessed in conjunction with son, daughter-in-law, colorectal surgeon and multiple	**Hgb A1C**-5.5 (4-6%) WBC: 6.82 (4-11) HB: 9.5 (13-17) HCT: 29.3 (40-52%) PLT: 258 (150-400) INR: No data available APTT: No data available Na: 142 (135-145) K: 3.7 (3.5-5) Cl: 103 (95-105) CO2: 28 (23-29) BUN: 9 (8-21) CREAT: 0.9 (0.8-1.3) GLUC: 75 (65-110) Mg: 1.9 (1.5-2) Pre-albumin 18 (16-40)

WOC Complex Plan of Care

WOC nurses. Assessment of stoma, peristomal skin, and mucocutaneous separation full noted. Patient has moisture associated skin damage on abdomen from effluent as patient stated she has not been able to apply a pouch and nursing has not been able to apply a pouch. Domeboro medicated soak rash solution (Burow's solution) applied for 20 minutes after gently cleansing with mild soap and water on abdomen skin around the mucocutaneous separation wound/peri-wound. Then pat dried gently. Stomahesive Protective Powder applied on peri-wound mucocutaneous separation wound and sealed with 3M Cavilon and allowed to dry. End ileostomy stoma noted retracted into mucocutaneous separation wound and facing at 9 o'clock and mucus fistula not visualized as fully retracted. Unable to isolate mucocutaneous separation wound from stomas due clinical presentation. Colorectal surgeon in agreement to pouch all together due clinical presentation. Mucocutaneous separation and stoma pouched together with multiple WOC nurses' collaboration and WOC student. She also has an upper medial abdomen wound from laparoscopic incision site with small amount of loose slough tissue present. Conservative sharp debridement of wound slough completed by Colorectal Surgeon. Wound bed now healthy and pink. Wound measures 0.4 cm x 0.3 cm. Wound cleanse with normal saline and covered with Allevyn foam dressing. She is returning to a rehab facility and may discharged home this coming week. Patient to follow up in 7 days with WOC nurse and Colorectal Surgeon.	6/23 CT scan -Significant amount of pneumoperitoneum with thickening of the colon diffusely No other imaging on file

WOC Complex Plan of Care

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Alteration in bowel function secondary to end ileostomy and mucus fistula. Stoma is in mucocutaneous junction separation wound retracted; full mucocutaneous separation. The stoma is facing 9 o'clock and the Os is is in the center. Peristomal skin ulcerated with red tissue; concave, deep creases at 3 and 9 o'clock; firm supportive tissue; green effluent and milky drainage. End ileostomy Os in center of stoma and facing the right side in the wound bed. Mucus fistula not visualized but milky drainage noted. Mucus fistula Os retracted into wound. Around mucocutaneous junction wound denuded skin, very painful, and firm. Output of stomas not known as patient unable to place a pouch or nursing prior to arrival per patient. Tissue around retracted stoma is beefy red and healthy (in wound bed)	-Use ConvaTec Sensi Care No Sting Adhesive Remover wipes to gently release the worn pouch from the skin. -Gently pat and cleanse with mild soap and tap water on soft gauze. Pat dry. -Apply soft gauze Medline soaked in Domeboro's soak solution on affected erythema skin on peri-wound for 20 minutes. Pat dry. -Apply Stomahesive Protective Powder ConvaTec on peri-wound denuded skin and seal with 3M Cavilon. Allow to dry. -Apply ¼ of strip paste coiled at 3 and 9 o'clock ¼" from peri-wound. -Cut Hollihesive skin barrier wedges in petaling fashion, caulk with ConvaTec Stomahesive paste. -Apply medium Hollister convex oval ring to the back of the 1 ¾" Marlen shallow convex drainable pouch. -Apply Marlex elastic belt and	No peri-wound erythema noted on mucocutaneous wound separation Mucocutaneous junction wound separation smaller Patient states pouch is staying on for 2-3 days Patient not self-isolating and returned to activities of daily living. Patient is able to complete pouch change herself. -Mucocutaneus junction wound and retracted stomas all included in the pouching system.	The firm abdominals supportive tissue requires a shallow type of convexity with flexibility and softness as well as the ring to help secure the seal and add a small amount of convexity with the ring as well (Colwell & Hudson, 2022). The belt will add convexity and secure the pouching system more as the stoma is retraced into the mucocutaneous junction separation wound. This will help with the seal as this is a double barrel stoma of a mucus fistula and end ileostomy (Colwell & Hudson, 2022). Mucocutaneus junction wound due to severe mucocutaneous separation. The stoma and mucocutaneous separation wound included in pouch system without isolating stoma due to ileostomy facing 9 o'clock. Usually, mucocutaneus wound is isolation from stoma(s) when pouched. Due to clinical

and small serous drainage.	secure with fiting two fingerbreadths -Monitor output and amount		presentation, unable to isolate stomas (Pittman, 2022).
No signs or symptoms of infection of mucocutaneous separation wound, stomas, and wound from laparoscopic midabdomen	Closely monitor for signs and symptoms of infection of mucocutaneous separation wound, stomas, and wound from laparoscopic midabdomen on all visits and at rehab facility of patient.	Patient states and demonstrates no signs or symptoms this visit of infection. Patient will state on next visit no signs or symptoms of infection	Fecal contamination is high and infection risk is high as this is a full mucocutaneous separation, subcutaneous defect is likely and infection can happen especially since stomas could not be isolated from peristomal wound/mucocutaneous separation wound and retracted fully mucus fistula (Pittman, 2022).
Electrolytes within normal limits, stoma retraction of mucus fistula and end ileostomy noted as previously described.	Nonviable tissue on wound bed of laparoscopic site debrided by Colorectal Surgeon. Monitor electrolytes and supplement per MD order, necrosis on mucocutaneous separation and abdominal wound laparoscopic, and worsening retraction	Patient verbalizes mucocutaneous separation smaller and is smaller upon assessment at next follow up visit in 7 days. Patient will verbalize no worsening retraction, electrolytes remain within normal levels.	In mucocutaneous separation electrolyte imbalances may be noted and need supplementation as well as necrosis and retraction. The patient has retraction and worsening of retraction needs continue to be monitored (Shingo et al., 2020).
Midabdominal laparoscopic site wound measures 0.4 cm x 0.3 cm, partial thickness with pink healthy tissue with serous scant drainage. Peri-wound pink, healthy, and intact.	Cleanse with Sea Clens wound cleanser. Apply Allevyn foam dressing. Change every 3 days and PRN if showers, wet, soiled, or strikethrough.	Patient states at next follow up visit of wound bed measuring smaller, continue to heal, and look healthy with no signs or symptoms of infection and will be reflected by WOC assessment.	Sea Clens has wound surfactant that helps loosen debris and slough. This will help with debridement. Allevyn will help maintain moist wound healing environment and allow for autolytic debridement. Covering it will also help protect it from getting infected as stomas present in abdomen with mucocutaneous full

			separation (Bonham, 2022).
Monitor for dehydration signs and symptoms: reduced energy, fatigue, dizziness, lightheadedness with activity, urine with dark color, high effluent output, and decreased urine output. Manage dehydration signs and symptoms per provider's order.	Care for patient as directed by MD for any signs or symptoms of dehydration.	Patient states ileostomy output around 1,100 cc and on follow up visit patient will report same output amount Patient will report no signs or symptoms of dehydration noted on follow-up visit.	The output of ileostomies is greater than most ostomies and places them at higher risk for dehydration and blockages. Nutritional intake is crucial to prevent blockages and dehydration. Dehydration signs and symptoms include reduced energy, fatigue, dizziness or lightheadedness with activity, urine with dark color, high effluent output, and decreased urine output (Rubin, 2022).
Monitor oral diet intake and limit insoluble fiber and foods as oral intake with a intake diary of 3-4 days.	Discuss oral intake to decrease risk of blockage and dehydration. Chew foods well especially fibrous foods. Avoid raw fruits and vegetables for 6 weeks after surgery. Foods for diarrhea control applesauce, bananas, toast, and tapoika. Avoid gas producing foods: soy cabbage, carbonated drinks, dairy products, milk, onions, and nuts. Odor producing foods eggs, fish, garlic, onions, broccoli, and baked beans. Foods that may cause an obstruction: peels, skins, celery, Chinese vegetables, corn/whole kernel, coconuts, dried fruits, mushrooms, oranges, nuts, pineapple, popcorn, seeds, and coleslaw. Avoid drinking through a straw or chewing gum.		Normal ileostomy output is <1,200 mL per 24-hour period. More emptying or watery effluent can be an indication of dehydration (Carmel & Goldberg, 2022). Balanced nutrition and adequate intake for patient's with ostomies, especially ileostomies is critical Carmel & Goldberg, 2022).

WOC Complex Plan of Care

Review patient chart for nutrition consult for wound care and stomas need	-Nutrition consult placed and follow up on recommendations on next follow up visit **Alternate pouching system:** Marlen Deep Convex Transparent Ultralite Pouch	Note states nutrition consult placed by provider and note seen on chart. Patient following nutrition recommendations by dietician per patient. Patient states she is eating appropriately and not skipping meals. Patient will state at next visit of having followed limited insoluble fiber and food intake. Patient's intake is adequate calories, minerals, and protein. Patient's nutrition is adequate in this visit and will state adequate intake next visit of fluids and food	Adequate nutrition is needed for wound healing and for appropriate wound healing process in order to not become chronic. This entails amino acids/proteins, calories, vitamins, minerals to help prevent skin injury or breakdown. Adequate nutrition is necessary to maintain the biochemical processes of the internal body (Beitz, 2022; Borchert, 2022).
Monitor signs for blockage of end ileostomy: liquid or watery effluent spurting out, abdominal fullness or bloating, cramping, swelling on stoma, nausea/vomiting, and no output from stoma.	No signs or symptoms of blockage noted or stated by patient. Continue to monitor patient	Patient states no signs or symptoms of blockage. Patient at next visit will state no signs or symptoms of a blockage	Ileostomies are known to have occurrences of food blockages and WOC nurse can help alleviate blockage with 30-50 mL of normal saline instilled into stoma until blockage is relieved with catheter of 14-16 Fr (Carmel & Goldberg, 2022).
Assess for consult of physical therapy (PT) for physical strength and occupational therapy (OT) for activities of daily	Consult placed for PT and OT Educate patient on steps of pouch change with each change to include:	Patient will verbalize PT and OT services at rehab facility. Patient progressing toward goals.	Physical therapy will help strengthen the patient. Occupational therapy will help patient achieve independently activities of daily living for the goal to live home.

	Prepare for pouch change: * Obtain all equipment needed for pouch change and measure skin at top of mucocutaneous junction separation wound/peri-wound * Remove pouching system gently with Essenta No Sting Adhesive Remover using push-pull method *Cleanse skin with warm water and mild soap gently by patting *Gently dry skin by lightly patting *Measure peri-wound skin and cut-to-fit pouch 1/8” larger *Apply Domeboro’s soak solution soaked in soft nonwoven gauze Medline for 20 minutes * Remove backing paper from clean pouch *Apply clean ring attached to pouch. *Apply hand over stoma for 5 minutes to increase adhesion Empty pouch when 1/3 to ½ full. Provide education on how to empty pouch, record I & O, and for patient to do on own or help with assistance of Rehab facility nurses until able to do independently with goal to do on	Patient demonstrated attached ring to pouch system. Patient at next visit will remove pouching system with adhesive remover with push-pull technique; apply Domeboro’s soak if needed for 20 minutes; apply Stomahesive powder and seal with 3M cavilon (if needed), and apply ring with pouch system on appropriately.	Mobility and completion of activities of daily decreases the risk of a pressure injury. The more mobile and independent a patient is, the less likelihood of acquiring a pressure injury (Borchert, 2022). Patient to progress towards independence helps the patient feel empowered and as part of activities of daily living (Borchert, 2022).

	own in the future Measure output for monitoring of dehydration Encourage patient to participate in pouch change and advance to independence. First start with preparing skin barrier wafer and progress with time as patient tolerates to a full pouch change. Include patient's son in education as patient allowed this. Long term goals: Wear time 3-4 days: *Change pouching system every 3-4 days and prn for leaking		
Body image concerns: Patient saw full stomas retracted with mucocutaneous separation and stated "Oh my god. This looks really bad."	Use open-ended questions Acknowledge patient feelings this is difficult situation for the patient and assure it can make progress toward healing with appropriate care as instructed by WOC nurse and colorectal surgeon. Provide emotional support. Discuss with patient end	Patient verbalized responding well after providing emotional support and acknowledging feelings. Patient at next visit will verbalize feeling better about her stomas status and understanding of it taking time to heal.	Individuals continuing with their activities of daily living and adapting to life after their surgery will help with their quality of life and decrease risk of depression (Rubin, 2022).

	ileostomy and mucus fistula tend to not cause odor and the foods that causing odor and strategies for managing gas/odor (deodorant/lubricating drops; staying away from foods that cause gas for them; how to allow air to come out in one piece and use of filters; oral deodorant). Discuss methods that work for an individual will vary person to person. Encourage patient to join local stoma support group	Patient states foods that will cause odor and gas, as well as how to manage and figuring out what works for them is by trialing and differs person to person.	Individuals having the ability to be prepared of what may occur and how to manage helps ease anxiety as well as increase their comfort with their new stomas. This hands them the tools to be successful with their stomas, feel better, and control. Additionally, methods that work for an individual differ from one person to the next and trialing will help determine what works for the individual (Carmel & Goldberg, 2022).
Assess chart for Psychiatry consult	Discuss with Primary Service of Psychiatry consult	Notes indicate Psychiatry consult placed by Primary Service. Patient will verbalize feeling better with full mucocutaneous separation and coping well at next visit in 7 days. WOC nurse to review Psychiatry recommendations at next visit with patient	Individuals can start isolating and decrease in quality of life with body image concerns, relationships with family or partners, and sexual concerns. It is imperative for this patient to act proactively (Rubin, 2022).

WOC Complex Plan of Care

Pain control Mucocutaneous separation and laparoscopic abdominal wound assess. No pain at laparoscopic wound. Pain at Mucocutaneous separation very tender “8” with cleansing and no pain when not touching or cleansed.	Reassess pain at end of the visit and all follow up visits, as well as bedside nursing to continue monitoring for pain with incontinence associated dermatitis and pressure injuries. Patient to take medication at rehab facility acetaminophen 650 mg PRN every 6 hours for pain while at home as part of home medications. Call WOC staff and Colorectal surgeon’s office if changes in mucocutaneous separation and/or wound on abdomen laparoscopic incision site noted such as necrosis; signs and sympotoms of infection increase in drainage, purulent drainage, erythema on peri-wound/peri-stomal, induration, warmth, swelling, fever). Contact Colorectal surgeon office and WOC nurse for any worsening or changes of worsening. Reassess pain within 1 hour after pain management interventions given. Document with additional interventions as indicated. Encourage distraction, slow deep breaths, and self-guided imagery	Pt. reports pain reassessment at “5” after pain medication administered and completed cleansing. Pain will verbalize less pain on same pain scale used at follow up visit in 7 days. Patient teach back of pain relief techniques with start of pain and/or	Using an objective pain scale to help determine any pain and same pain scale previously used for reliability (Hull et al., 2022). Patient will have follow-up visit with WOC nurse and Colorectal surgeon in 7 days. Assessment of pain is imperative for the patient as a mucocutaneus separation tends to cause pain and wounds as well. Frequent assessment of pain whenever patient is seen with an approved Pain Scale to help pain be managed by a Provider before it worsens and is more difficult to treat (French et al., 2023; Hull et al., 2022; Pittman, 2022).

	at first sense of pain and in conjunction with acetaminophen Assess pain prior to pouch changes using validated pain scale (1-10) and pain reassessment after pouch change. Use distraction nonpharmacologic methods to assist with pain management. Administer pain medication at next follow up visit prior to pouch change 30 minutes before. Assist with position changes for comfort as needed.	when takes acetaminophen	Nonpharmacological methods for managing pain have been shown to be effective (Hull et al., 2022).

References:

Beitz, J. M. (2022). Wound healing. In L. L. McNichol, C.R. Ratliff, & S.S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 38-54). Wolters Kluwer.

Borchert, K. (2022). Pressure injury prevention: Implementing and maintaining a successful plan and program. In L. L. McNichol, C.R. Ratliff, & S.S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 395-423). Wolters Kluwer.

Carmel, J., & Goldberg, M. T. (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. 189-200). Wolters Kluwer.

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

Dasari, N., Jiang, A., Skochdopole, A., Chung, J., Reece, E. M., Vorstenbosch, J., & Winocour, S. (2021). Updates in diabetic wound healing, inflammation, and scarring. *Seminars in Plastic Surgery*, *35*(3), 153-158. https://doi.org/10.3390/jcm9061967

Ffrench, C., Finn, D., Velligna, A., Ivory, J., Healy, C., Butler, K., Sezgin, D., Carr, P., Probst, S., McLoughlin, A., Arshad, S., McIntosh, C., & Gethin, G. (2023). Systematic review of topical interventions for the management of pain in chronic wounds. *PAIN Reports*, *8*(5), 1-11. https://doi.org/10.1097/pr9.0000000000001073

Pittman, J. (2022). Stoma complications. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 270-282). Wolters Kluwer.

Shingo, T., Tan, K. Y, Miyakura, Y., Fukano, R., Oshima, M., Konishi, F., & Rikiyama, T. (2023). Current management of intestinal stomas and their complications. *Journal of the Anus, Rectum, and Colon*, *4*(1), 25-33. https://doi.org/10.23922/jarc.2019-032

Rubin, M. (2022). Surgical management of Crohn's disease and ulcerative colitis. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 71-99). Wolters Kluwer.

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: _____