

WOC Complex Plan of Care

/Name: Marisa Perez Date: 7/19/24

Clinical Focus: Wound 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
<p>J.S. is a 69 year old male with a history of BPH, Cataracts, Cervical spinal stenosis, GERD, Mixed hyperlipidemia, Pulmonary hypertension, sarcoidosis of lung, and surgical history of bilateral lung transplants and tracheostomy. Patient also has a G-tube for nutrition therapy. Admitted for Acute on chronic respiratory failure with hypoxia. Patient acquired a pressure injury in the hospital on a previous admission. Wound care team has been on consult for the patient's wound since re-admission 6/6/24. The wound care team has followed up with the patient every two to three weeks to monitor progress. Patient was seen three weeks ago on 6/27/24 by wound team where the wound was assessed and found still to be an unstageable pressure injury to the sacrum. It was noted that the amount of adherent yellow slough was less than that of the patient's previous admission. The wound had been managed by family and home care nurses at home while the patient was out of the hospital.</p> <p>WOC nurse consulted for wound care. Patient noted to be up to the chair with physical therapy and patient's wife present in room. On last visit from wound team, patient was unable to speak, but patient able to respond today as he had a voice box in place. With assistance from physical therapy, the patient agreed to stand so we could re-assess his sacral wound. Previous dressing of Allevyn silicone foam border dressing and Aquacel were removed. Wound bed was cleansed with normal saline and pat dry with 4x4 gauze pad. A new picture and measurement were taken and</p>	<p>WBC 6.10 RBC 2.83 HGB 8.1 HCT 25.6 Platelets 99 Neutrophils 71%</p> <p>Sodium 127 Potassium 3.8 Chloride 89 CO2 26 Protein 6.0 Albumin 3.8 Calcium 9.3 Glucose 141 BUN 63 Creatinine 3.60</p>

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added to the patient chart. Patient verbalized tenderness when sacrum cleansed. Wound was measured at 3cm x 3cm x 0.4cm. Peri-wound skin was noted to be moist with blanchable erythema. Wound has evolved from unstageable to stage 3 pressure injury. Wound bed is noted to still have a thin layer of adherent yellow slough, but the red wound bed is now visible. A moderate amount of yellow drainage noted. No odor noted. WOC nurse applied ConvaTec skin barrier wand to the peri-wound skin, allowed for drying. Next, Aquacel was applied directly to the wound bed followed by an Allevyn silicone border foam dressing. Patient was getting weak standing and requested to sit back down once dressing was re-applied. WOC nurse discussed the importance of turning and repositioning to relieve pressure to the sacrum. Patient understood, but stated he is unable to turn due to inability to breath in those positions. The WOC nurse made the suggestion of wedges and the patient stated it does not work for him, but he would be willing to attempt. Also discussed at the end of the visit was how often to change the dressing. Per a chart review, the last time the patient was seen by the WOC nurse, dressing was being changed every other day. Due to the moisture noted to the peri-skin on this visit, the WOC nurse changed dressing changes to every day and as needed. Patient continued to work with physical therapy. Pt tolerated visit and care provided.

Current Medications:

Vancomycin 125 mg ORAL liquid BID
Chlorhexidine Gluconate 15 ml ORAL rinse BID
Lactobacillus rhamnosus 10 billion cell capsule DAILY
Atorvastatin 10mg at BEDTIME
Aspirin 81 mg ORAL/FEEDING TUBE DAILY
Aripiprazole 2 mg ORAL/FEEDING TUBE TID PRN
Insulin regular (short acting) SUBCUTANEOUS 3 times per day
Ondansetron (PF) 4mg IV Q 8 hrs PRN
Azithromycin 250 mg ORAL MO-WE-FR
Sodium chloride 7% solution 4mL INHALATION BID
Sulfamethoxazole-trimethoprim 400-80 mg ORAL MO-WE-FR
Ipratropium 0.02% 0.5 mg INHALATION Q 4hrs while awake
B Complex-Vitamin C-Folic Acid ORAL/FEEDING TUBE DAILY
Midodrine 2.5 mg ORAL/FEEDING TUBE BID
Famotidine 20 mg ORL.FEEDING TUBE Q48 hours
Prednisone 5mg ORAL/FEEDING TUBE DAILY

INR not drawn
HgbA1C not drawn

CT – No recent results

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<p>Braden Score Sensory Perception – Slightly Limited (3) Moisture – Occasionally moist (3) Activity – Walks Occasionally (3) Mobility – Very limited (2) Nutrition – Adequate (3) Friction and Shear – Potential problem (2) Total: 16 – At Risk for Skin Breakdown</p>	<p>requested by patient/family - Notify wound care nurse if changes noted; increased exudate, increased nonviable tissue, malodorous exudate/wound bed, increased pain, etc.</p> <p>2) Turn and reposition q 2 hours right to left, keep off coccyx and ischial wounds, using wedges behind back and behind thighs</p> <p>- Work with PT and OT to continue strengthening mobility</p> <p>3) Continue using low air loss bed while in the ICU</p> <p>4) Decrease friction/shear. Place head of bed at 30 degrees. Use foam wedges for offloading sacrum.</p> <p>5) Follow nutrition’s recommendations for tube feeding</p> <p>6) Monitor blood sugar and treat per ordered sliding scale</p>	<p>Nurses’ notes in chart show patient being turned every 2 hours with use of wedges previously ordered. Patient has been compliant with regular turns.</p> <p>Chart review shows patient consistently working with PT and OT on daily basis.</p> <p>Chart review shows patient still in ICU with same bed system.</p> <p>Chart review shows patient’s HOB at 30 degrees.</p> <p>Chart review shows patient still getting TPN feeding</p>	<p>allows for non-traumatic dressing removal, also helping lessen pain. In addition, alginates that form a gel aid in autolytic debridement (Jaszarowski & Murphree, 2022).</p> <p>Alternative: Medline Skintegrity wound cleaser, Excel Sap 4x4 border dressing.</p> <p>2) Studies have shown that wedges are most effective over pillows in reducing pressure injuries with proper wedge placement (Borchert, 2022).</p> <p>Patients have shown to have better outcomes with activity and mobility with early intervention (Borchert, 2022).</p> <p>3) Low air loss mattresses help to manage the microclimate of the skin by providing continuous airflow to the skin. They also help in distributing pressure evenly by adjusting to each patient (Mackey & Watts, 2022).</p> <p>4) Pressure injury risk increases when shear and friction are present (Mackey & Watts, 2022).</p> <p>5) A possible benefit of enteral feeding is less risk for pressure injury development and/or improve healing of wounds (Friedrich et al., 2022).</p>
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		Chart review shows regular lab draws with blood glucose levels as well as POC glucose checks.	6) If glucose levels are managed poorly, it can effect wound healing. Sugar control is necessary for diabetics and wound patients (Friedrich et al., 2022).
Bilateral Heels	<p>1) Apply Tru-View offloading boots to bilateral lower extremities. - Remove daily to assess skin. If note new pressure injuries, notify wound care nurse</p> <p>Alternative: Prevalon offloading boots</p>	<p>- Chart review nursing note shows patient wearing boots when in bed.</p> <p>No new pressure injuries noted to BLE</p>	1) Heel offloading is key in helping to heal or prevent injuries in patients with mobility issues (Bonham, 2022).

References:

Bonham, P. (2022). Assessment and management of patients with wounds due to lower extremity arterial disease (LEAD). In L. L. McNichol, C. R. Ratliff, & S. S. Yates, (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 493–538). 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. 396–424). Wolters Kluwer.

Friedrich, E., Posthauer, M. E., & Dorner, B. (2022). Nutrition strategies for wound management. In L. L. McNichol, C. R. Ratliff, & S. S. Yates, (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 116–135). Wolters Kluwer.

Jaszarowski, K. & Murphree, R. W. (2022). Wound cleansing and dressing selection. In L. L. McNichol, C. R. Ratliff, & S. S. Yates, (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 157–171). Wolters Kluwer.

Mackey, D. & Watts, C. (2022). Therapeutic surfaces for bed and chair. In L. L. McNichol, C. R. Ratliff, & S. S. Yates, (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 425–445). Wolters Kluwer.

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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: _____