WOC Complex Plan of Care

Name: _____Marisa Perez_____ Date: __7/24/24_____

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
61 year old male with a history of diabetes mellitus type 2 with peripheral neuropathy, obesity, anemia, depression, Barrett's esophagitis, HTN, HLD, OSA on CPAP, PE, DVT, UTI. Patient was admitted to an outside hospital 4/3/24 for cholecystitis s/p laparoscopic gastric cholecystectomy, 4/6/24 was converted to open cholecystectomy with need for gallbladder to be bivalved. Post-op complications of bile leak for which he had ERCP with sphincterotomy 4/8/24. Patient still had abdominal sepsis, 4/11/24 underwent another surgery for pelvic abscess from either diverticulitis or appendicitis with entro-colic fistula. Patient then had further surgery for fistula resection, resection of the sigmoid colon and colostomy, I&D of abscess, appendectomy, hernia repair with mesh. This surgery produced two large wounds, one midline and one horizontal to the right abd which required NPWT. Patient had further complications with UTI, renal and respiratory failure. Patient was ventilated, but extubated 4/14/24. Multiple further surgeries for I&D of abscess. Upon arrival to CCF, 7/14/24, patient had CT of abdomen and pelvis with IV and oral contrast. Scan showed persistent retroperitoneal fluid and gas collection with drain in place that is aligned with the base of the cecum which may represent a leak. This also showed coloncutaneous fistula coming from the base of the cecum. Allergies: codeine, latex, penicillins	**Hgb A1C**- lab not drawn WBC: 12.80 HB: 8.2 HCT: 26.4 PLT: 318 INR: lab not drawn APTT: lab not drawn NA: 139 K: 3.5 CHLOR: 100 CO2: 25 BUN: 53 CREAT: 0.78 GLUC: 210 MG: 2.1 CA: 10.3

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ET/WOC *"ET" is a dated term that reflects varying credentials in different demographic areas. Try to avoid in charting.* team in to see patient today for fistula management/pouch change before D/C. Patient was greeted and identified by name and DOB. Wife present in room. Change and education completed today. Patient being D/C'd to LTAC facility.	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Alteration in bowel function secondary to fistula and colostomy (no output from colostomy). Six total ECFs (4 matured with green liquid effluence and 2 openings with mucoid/watery effluence from abd wound dehiscence. Fistula exit central to abd wound. Wound bed is red and moist with some scattered gray tissue.	Use Coloplast MAXI pouch with inner radial slits from 5-7 o'clock with large bore gravity drainage system. *– Consider a window pouch.* *Alternate pouching system: ConvaTec Eakin fistula pouch with large bore gravity drainage system.* *Consider pain mgmt..* Wound care: -Apply Stomahesive powder as needed to irritated or denuded skin with each pouch change. Dust off excess powder. Seal with 3M Cavilon skin barrier film. Educate patient on steps of pouch change with each change to include: Prepare for pouch change: * Assemble needed equipment	Chart review shows pouching system without leakage since last changed. Wound appears better with dressing measures being taken. – *be specific.* Patient has pouch change instructions and understands what to look for if any issues arise. Patient will take an extra copy of dressing instructions to LTAC.	Protecting the skin and containing effluence should be done as soon as fistulas form. Keeping the pouching system simple for other caregivers and checking the pouch seal frequently allow for beneficial outcomes (Nix & Bryant, 2022). Intervention should have options for skin protection and containment of effluence and fistula (Nix & Bryant, 2022). Education and emotional support are important aspects of an effective plan of care (Nix & Bryant, 2022). *– include in POC.*

	* Remove pouching system with push-pull technique and adhesive remover as needed. *Cleanse skin with warm water and pat dry. * Apply Hollihesive wedges in petaling technique circumferentially slightly overlapping. From 3-5 and 7-9 o'clock. *Use Stomahesive paste to caulk all seams. *Apply clean, cut pouching system *Use Hytape to secure window lid and prevent leaks. *Picture frame pouch with Mefix tape. *Attach pouching system to Hollister large bore gravity drainage system. Educate patient on checking the drainage cord for any twists or kinks. Include wife in discussion per patient request. *– how often should this be done?* Communicate orders to LTAC facility. Long term goals: Wear time 4-7 days: *Change pouching system every	Patient and wife understands they may need to adjust tubing to allow for proper drainage of effluence. Continuity of care achieved, orders faxed to facility and copy sent with patient. Patient wear time of 6 days at this time. Review of chart shows no leaks.	Fistulas are managed with either dressings or containment devices. You must assess a patient to determine the best options for them (Nix & Bryant, 2022).

	4-7 days and prn for leakage - *ok*		
Diabetic, obesity, decreased nutritional status	TPN ordered for patient. Nutrition on consult.- *consult with questions?* Limit water intake to limit fistula output. *– this is vague and a potentially negative directive. Be as specific as we can, we don't want to subject the patient to dehydration/risks. This needs to be specific and in line with nutritional orders.* Consult diabetic educator. Obtain lab work to ensure electrolyte balance. *– who gets this report?* *When should the patient seek WOC follow-up?*	Patient seen by nutrition therapist and TPN still in place for feeding. Chart review shows fistula output lessening over time. Diabetic educator has seen patient. Chart review showing lab work getting better than previous blood draws.	Tube feeding is used to prevent and manage fistulas (Nix & Bryant, 2022). Output can be managed by using medications or limiting intake to what is needed to maintain a healthy intestinal mucosa (Nix & Bryant, 2022). Diabetes and poor sugar control is a risk factor for fecal incontinence (Lonergan Callan & Francis, 2022). Patients with ECF/EAF are at increased mortality and morbidity if fluids and electrolytes are imbalanced (Nix & Bryant, 2022).

References:

Lonergan 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. 484-519). Wolters Kluwer.

Nix, D. & Bryant, R. A. (2022). Fistula management. In J. Carmel, J. Colwell, & M. T. Goldberg, (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 283–303). Wolters Kluwer.

Consider further sources past texbook

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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*	*2*	*What is currently in place to manage this patient?*
	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*	*9*	*See my comments*
	Propose alternative products. Include generic & brand names	*4*	*4*	
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	*6*	*6*	
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*	*.5*	
	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 Marisa- see my comments throughout. Make sure to continue to apply concepts to your future work and studying, When charting assessment, make sure you identify what is currently being done, and differentiate it from what you direct as the specialist. Reach out with any further questions. This assignment has reached the 80% threshold and no further work is needed on it.

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Reviewed by: _____Mike Klements Received 7/25/2024_____ Date: __7/25/24