WOC Complex Plan of Care

Name: Jennifer Biggs Date: July 2024 ***Need actual date***

Clinical Focus: Wound x 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
MG is a 65 year old female with a significant past medical history including hypoglycemic brain injury, right hemispheric stroke, epilepsy, HTN, COPD, diabetes, acute renal failure, stage 3 kidney disease, and chronic anemia who has been admitted from LTAC with MRSA bacteremia. **LTAC notes documented chronic wounds as follows:** **1. Stage 2 coccyx wound** **2. Left metatarsal head wound** **3. Left lateral breast wound** **Upon arrival from LTAC, wounds were observed at other sites and WOC nursing was consulted for wound care.** **General: The patient is intubated and does not arouse to voice or follow commands. Patient has a tracheostomy.** **O2 therapy: Trach Collar, Liters: 10, %FiO2: 35** **GI: FMS to gravity drainage draining brown, yellow liquid stool** **GU: Anuric** **Skin: Skin was assessed with the staff RN and the following was noted:** **- Forehead wound of unknown etiology. Wound measurements 2.5cm x 6cm x 0.1cm. Periwound intact, wound edges irregularly shaped, no drainage or odor. Left open to**	**Labs:** **WBC 10.63** **HB 8.6** **HCT 25.8** **PLT 106** **Na 139** **K 3.8** **Chor 104** **CO2 19** **Creat 5.86** **BUN 78** **Gluc 108** **CA 9.0** **TPROT 7.2** **ALB 2.7** **MG 2.1** **Sed rate 120** **INR 1.1**

air. - **Left 2nd toe wound with unknown etiology. Wound measurements 0.8cm x 1cm x 0.3cm with serosanguinous drainage and exposed bone. Wound bed surrounding bone with 80% slough. Strong malodor with macerated periwound black, brown, red and yellow mixed color. Lower half of toe is easily moveable with grimancing on palpation. Broken bone suspected. Cleansed with wound cleanser and applied a moist contact layer and clean gauze dressing.** - **Left buttock extending onto bilateral buttocks unstageable pressure injury. Wound measurements 12cm x 14cm x 0.2cm. The area is red, pink, brown and purple open tissue. Few satellite lesions present. Edges are intact and irregular and the surrounding skin is slightly macerated. Cleansed with Vashe. Applied protective barrier ointment and ABD pads to the area. Positioned on left side.** - **Left breast wound was found to have resolving MASD.** **Current medications:** - **Acetaminophen 1000mg per feedback tube every 6 hours PRN for pain** - **Insulin Regular on a sliding scale every 6 hours** - **Dextrose 15gram oral PRN** - **Glucagon 1mg SubQ injection PRN** - **Vancomycin; dosing monitored by pharmacy 125mg QID per feedback tube** - **fentanyl 50mcg/ml; 25mcg injection IV Every 1 hour PRN Pain** - **Meropenem 500mg in NaCl 0.9% 100ml vial/bag IV Daily at 6pm** - **Pantoprazole 40mg IV injection BID** - **Brivaracetam 100mg tablets per feedback tube BID** - **Lacosamide 200mg BID per feeding tube** **Allergies** - **Fosphenytoin** - **Pneumococcal vaccine** - **Duloxetine** - **Heparin** - **Sulfamethoxazole** - **Tramadol** - **Trimethoprim** **Tube feeding** **Wound care will continue to follow.**	**APTT 33.9** **Urine culture >=100,000 CFU/ml Klebsiella pneumoniae** **Pending Xrays and MRI for diagnosis of Left 2nd toe wound**

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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Forehead of unknown origin. This appears to be from positioning against bed rail possibly during skin care.	Forehead 1. Clean forehead wound with normal saline. 2. Apply sween cream BID ***Alternate?*** 3. Monitor closely during turning and repositioning to ensure no forehead contact occurs with bedrails or tubing. ***Then what?*** 4. Notify wound care nurse if changes in the wound are observed.	Wound without exudate Wound area is moist due to perspiration making dressing difficult to adhere. ***ok***	Wound area moist due to perspiration. Sween cream can protect wound from infection while keeping the wound bed moist (Ermer-Seltun & Rolstad, 2022). ***Why do you want to keep wound moist and prevent infection?***
Left second Toe unknown etiology or origin.	Left second toe 1. Consult podiatry 2. Irrigate toe ulcer with 500 cc normal saline daily ***ok Seems like a lot of fluid***	Possible that the infection source could be necrotic toe or osteomyelitis and the source of the sepsis. ***Ok Should there be a work-up then to determine such? This is not an evaluation.***	Xrays are needed to determine if bone is broken and an MRI to determine if this is the source of infection. ***This should be a component of the POC Rationale for care related to toe?***
Buttocks pressure injury with moisture associated dermatitis with fungal infection present. Braden Score: Sensory Perception: 2 (very limited) Moisture: 1 (constantly moist) - Fecal incontinence, skin folds, obesity Activity: 1 (bedfast)	3. Paint with betadine ***Is this best practice?*** 4. Cover with sterile dressing ***Be specific. Is it truly sterile wound care outside of OR?*** Buttocks 1. Cleanse entire wound and peri-wound area with Vashe	Nurses notes indicate patient being turned every 2 hours. ***good*** Skin was not clean upon assessment. Gentle cleaning was needed to remove dead skin and drainage. ***Evaluation?***	Vashe is made of hypochlorous acid that keeps the skin's ph at 5.5 which is optimal for wound healing (urgo medical, 2024). ***This is not a scholarly source.*** Anti-fungal barrier cream will help reduce the fungal infection which is likely caused by excess moisture. The barrier cream creates a barrier between the

Mobility: 1 (completely immobile) Nutrition: 3 (adequate) - Tube feedings Friction and Shear 1 (problem) - Mobility is challenging at night after leakageFrequent repositioning due to incontinence Total: 9 Very High Risk	2. Cover wound and peri-wound with anti-fungal barrier cream such as Baza by Coloplast 3. Cover entire wound and peri-wound with ABDs to prevent friction and shear 4. Change dialy and PRN if soiled 5. Notify wound care nurse if changes noted Other interventions 1. Continue with FMS ***I do not note where a fecal management system is in use.*** 2. Turn and reposition q 2 hours right to left, keep off coccyx and ischial wounds, using wedges behind back and behind thighs 3. Place on Dolphin bed specialty surface 4. Decrease friction and shear by keeping bed at 30 degrees 5. Patient is anuric but if urine is produced, consider indwelling catheter and follow CAUTI protocol 6. Follow nutrition's recommendations for tube feeding	***Evaluation?***	borken skin the the environment and will help prevent further breakdown from moisture (Ermer-Seltun & Rolstad, 2022). ABD's can help keep the cream in place and protect against friction or shear. Antifungal powder dusted over the area followed by a zinc based barrier cream would be an alternative (Ermer-Seltun & Rolstad, 2022). ***ok*** Repositioning every 2 hours will prevent additional DTI over bony prominences (Borchert, 2022). A pressure redistribution surface like a dolphin bed will help prevent pressure injuries in high risk populations over bony prominences (Borchert, 2022). Positioning the head of the bed at 30 degrees or less minimizes shear risk (Borchert, 2022). Urinary catheter will prevent exposure to moisture from urine (Borchert, 2022). Adequate nutrition is needed for wound healing and to prevent further tissue breakdown

	7. Monitor blood sugar and treat per ordered sliding scale 8. Be meticulous with skin care paying special attention to skin folds and other areas pronie to moisture. ***Few alternative products not noted.***		(Friedrich, Posthauer, & Dorner, 2022). ***APA format*** Diabetics have an increased risk of impaired wound healing if blood sugar isn't controlled (Friedrich, Posthauer, & Dorner, 2022).

References:

Borchert, K. (2022). Pressure injury prevention: implementing and maintaining a successful plan and program. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Socialy core curriculum: Wound management* (2nd ed., pp. 396-424).

Ermer-Seltun, J. E. & Rolstad, B. S. (2022). General principles of topical therapy. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Socialy core curriculum: Wound management* (2nd ed., pp. 136-156).

Friedrich, E., Posthauer, M. E., & Dorner, B. (2022). Nutritional strategies for wound management. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Socialy core curriculum: Wound management* (2nd ed., pp. 116-135).

Urgo Medical. (2024). Vashe wound solution with pure hydrochlorous acid. https://www.urgomedical.us/products/vashe

APA format errors. Urgo is not a scholarly source. See syllabus for reference requirements

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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	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	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	11	
	Propose alternative products. Include generic & brand names	4	1	
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	1	
Rationale	Explain the rationale for identified interventions	6	4	
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1	0.75	
	Proper grammar & punctuation used	1	0.75	
	References: See the course syllabus for specific requirements on references for all assignments	1	0.25	
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50		37.75	

Additional comments:

Good attempt. Evaluative statements and product alternatives are minimal; contributing to lower score. Want to be specific with your rationales and match to your interventions. For example, why do you want to keep the wound moist?

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Reviewed by: _Kelly Jaszarowski_____ Date: __7/30/2024_____