WOC Complex Plan of Care

Name: _____Charina Hanley_____ **Date: ____7/23/24_____**

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
29 YOF who is 32 weeks pregnant (G2P0010) with history of congenital bladder extrophy. Suprapubic tube placed in patients bladder in Texas hospital in June due to urinary retention with multidrug resistant E. coli UTIs. This SPT became infected and disloged, and she was seen by urology surgeons at Cleveland Clinic on 6/25 to salvage the tube and perform cystourethroscopy. 14 Fr foley catheter now in place and sutured. Client now staying in Cleveland near hospital until scheduled C-section of her baby at the end of August. Urology will also be present for tis procedure. She is a practicing lawyer and is working remotely at this time. PMH: congetinal bladder extrophy, frequent UTIs including pyelonephritis, nephrolithiasis, absence of bladder continence in 2020 Current active medical problems: tachycardia, supervision of high risk pregnancy in third trimester, urinary retention, hyperemesis, insufficient weight gain dueing pregnancy in 3rd trimester, low lying placenta with hemmorrhage in 2nd trimester, obesity affecting pregnancy in 2nd	Vitals HR 108 BP 115/68 RR 18 O2 Sat 99% Temp 98.6°F Pain on Wong-Baker scale: 0 Height 170.2cm (5’ 7”) *Weight today and serial weight not recorded* Labs collected 7/14/2024 **Hemoglobin: 10.2 g/dL (L)** **Hematocrit: 32.3% (L)** Platelet Count: 274k/uL

trimester, bladder extrophy s/p reconstructive surgery, vitamin B12 deficiency, complicated UTI Surgical History: Surgery to correct bladder extrophy was performed on day of patients birth at hospital in Fort Worth, TX. At age 15 months, she underwent ureteral surgery. At age 4, bladder neck repair and collagen injection. 2019 dilation and curettage 1/2020 shockwave lithotripsy for R nephrolithiasis 9/2020 bladder extrophy reconstruction, pelvic saggital osteotomy, cystourethroscopy, UDS 6/25/2024 placement of open cystostomy tube (SPT) Allergy to latex Current prescriptions: Cyanocobalamin 50mcg tab PO daily PNV no.95/ferrous fum/folic ac (prenatal oral) PO daily Cephalexin (Keflex) PO daily Ferrous sulfate (iron) 325mg (65mg iron) tablet PO daily Seen today in clinic for WOCN Nursing consultation and pouch change. Client also has wound inferior to catheter site. Patient accompanied by her husband today. Peritube skin intact, and faintly pink from scar tissue from recent incisions. Transverse creases to base of inferior wound. Catheter remains in place, however external sutures no longer attached to skin. Prior pouch placed 4 days ago, leak present at 6 o'clock and central part of Hollihesive washer was washed away. Inferior wound appears to be healing compared to size and depth observed at previous visits, skin has thinly epithelialized over base of wound entirely, no granulation tissue observed. Client scheduled to return to clinic every Monday and Thursday until c-section to having poucinh system changed. Current pouching system: 1. Apply stomahesive owder to any areas of skin breakdown around SPT site PRN nuntil healed. Dust off excess.	CBC, CMP, and T/S taken, results pending

2. Apply thin layer of coloplast stip paste to each pubic crease 3. Apply strip paste between lower wound opening area and urethra 4. Apply thin “smile shape” cut wedge with radial slits to cover the above strip paste and caulk at area of lower wound opening w 5. Apply 1” x 4” wedges to cover stip paste at pubic creases 6. Apply Hollister Hollihesive skin barrier thin cut washer with radial slits around suprapubic catheter and lower open wound, caulk with paste 7. Apply Hollister premier 1 piece flat urostomy pouch cut pening 1 ¾” x1” off center bottom, and cut off reflex valve. Suprapubic tube is kept inside pouch 8. Frame flange with Mefix tape Goal wear time: 3-4 days	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Urinary incontinence “I leak a little urine when I strain to move or lift things or when I try to move my bowels” Suprapubic and perirethral skin is moderately moist. Small amount of urethral leakage noted during pouch change when patient repositioned on exam table, patient requested gauze to pat herself dry.	Patient will drink at least 2.7 L of water daily. Encourage patient to take breaks and walk at least three times a day with a distance that is tolerated. Refer to pelvic floor physical therapy with biofeedback and encourage use of “knack” manuever prior to strained movements or bowel movements.	Patient reports that she has been drinking at least 2.7 L of water a day. Patient reports she takes at least 3 short walking breaks during work days, and reports increased activity as tolerated on the weekends. Patient reports reduced volume and frequency of urthral leakage following regular use of “knack” maneuver with prescribed activities. Patient attends pelvic floor physical therapy sessions as prescribed, both before and after delivery of her	Fluid restriction is a common behavior in patients experiencing urinary incontinence (Thompson, 2022). This habit actually has been found to be detrimental to overall bladder health and adequate hydration is recommended, rather than restriction (Thompson, 2022). Regular physical exercise, when compared to a sedentary lifestyle, is associated with strengthening of pelvic floor muscles and prevention of urinary incontinence (Thompson, 2022). The “knack” procedure, taught by pelvic floor physical therapists, is

		baby.	a useful tool for patients experiencing stress incontinence, often cause by increased intraabdominal pressure (Thompson, 2022). Clients pregnancy is already creating stress on her urinary system, so adding interventions such as this will help to bolster her toolkit. The "knack" helps to support the urethra using pelvic floor muscles, to combat the increased pressure (Thompson, 2022). Stress urinary incontinence is a common complication in pregnancy, with up to 60% incidence in the US (Engberg, 2022). Due to this patients medical history, she is likely at heightened risk for continued incontinence following her delivery and removal of SPT, despite her scheduled C-section rather than vaginal delivery (Engberg, 2022). Early intervention to strengthen pelvic floor muscles and promote mind-body connection will be crucial to reducing her risk of lifetime complications. Inclusion of biofeedback encouraged to increase chance of success, as biofeedback has been shown to be more effective than PFMT on its

			own (Engberg, 2022).
Braden Score: 17 MILD RISK Sensory: 4 no impairment -able to voice pain and discomfort, A&O x3, responds appropriately Moisture: 2 Often moist -leakage of SPT as well as leakage of urine from urethra Activity: 3 Walks occasionally - working 9 hour days remotely at a desk, walks short distances, low endurance 2/2 pregnancy Mobility: 3 slightly limited - able to perform most hygiene tasks independently, difficulty bending down/reaching, needs some assistance getting up from laying down Nutrition: 2 probably inadequate -obesity in 2nd trimester, now concern for weight loss in 3rd trimester Friction/shear: 3 no apparent problem -moves independently, able to reposition herself without	Cleanse skin and perineal area gently after leaks and episodes of incontinence. Use rinse free, pH balanced cleanser, Perifresh no-rinse perineal cleanser from Dermarite. Pat dry. *Alternative: Medline Readybath Luxe wipes* Change sheets and garments as needed following urinary leakage. Encourage patient to take breaks and walk at least three times a day with a distance that is tolerated. Reposition every 2 hours when sitting or laying in bed for extended periods of time. Head of bed always elevated below 30 degrees. Apply stomahesive powder to any areas of skin breakdown around SPT site PRN until healed. Dust off excess. Apply Medline Remedy Clinical Protect Zinc Ointment to perineal areas that are often in contact with urine from urethral leakage.	Skin and perineal area continue to be free from breakdown, maceration, or other fungal complications that are due to excessive moisture. Skin over bony prominences remain intact. No breakdown, pressure ulcers, skin tears, or other injuries observed on body. Patient will report completing at least 75% of every meal, with shake or snacks in between meals. Weight will remain stable throughout rest of her pregnancy. Peri-tube and periwound area maintain integrity and do not become overhydrated or erythmatous.	When urine comes in contact with skin, it forms ammonia as it breaks down- the high alkalinity of ammonia interferes with the natural acidity of the skin, this impairing its protective mechanism and making the skin more vulnerable to pathogens and irritants (Thayer & Nix, 2022). No-rinse pH balanced cleansers are recommended over soaps and reusable washbasins as they are gentler on the skin and reduce risk of infection (Borchert, 2022). Regular repositioning and movement is heavily associated with reduces risk of pressure injuries due to decreasing the amount of time one part of the body is in contact with a surface (Borchert, 2022). Low angles on heads of beds promote reduces pressure on sacrum and coccyx, reducing risk for damage to the soft tissue on those areas (Borchert, 2022). If client is in a traditional bed, she should not be propped up on too

difficulty Age:29	*Alternative: Coloplast Baza Moisture barrier ointment* Continue to visit WOCN team twice a week for pouching changes and skin assessments. Apply no-sting liquid barrier to skin at 6 o'clock position when leaks do occur in pouching system. Refer to nutrition. Provide supplemental shakes if client struggling with poor appetite 2/2 hyperemesis.		many pillows that keep her higher than 30 degrees. Development of incontinence-associated dertatitis (IAD) is known to be a risk factor for developing pressure injuries (Thayer & Nix, 2022). Part of the care in preventing pressure injuris, therefore, is to prevent IAD before it starts. Clients reduced activity, mobility, nutrition, and increased moisture increase her risk of both pressure injuries and IAD. Skin that is overhydrated or macerated is experiencing a structural challenge at the layer of the stratum corineum of the skin (Thayer & Nix, 2022). This compromise leaves the skin to be even more vulnerable to the chemicals in urine that cause irritation (Thayer & Nix, 2022). Because of constant leakage at base of SPT insertion site, the patient would be at a much higher risk for complications if her urine was not being pouched. This system will continue to help isolate the majority of her skin from offending agents. Use of moisture barrier ointments will

			bolster this intervention since she is still having leakage from urethra in addition to the SPT. Liquid barrier films allow skin to be protected by enzymes while still allowing for evaporation to occue on skin, reducing damage to the stratum corneum (Thayer & Nix, 2022). Adequate nutrition is required for wound healing as well as wound prevention (Borchert, 2022). Client at risk for malnutrition due to hyperemesis and evidenced by weight loss.

References:

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.39–55). Wolters Kluwer.

Engberg, S. (2022). Stress Urinary Incontinence. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 213-231). Wolters Kluwer.

Thayer, D. & Nix, D. (2022). Incontinence-Associated Dermatitis. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 364-381). Wolters Kluwer.

Thompson, D. (2022). Management Fundamentals for Incontinence. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed., pp. 83-110). 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: _____