WOC Complex Plan of Care

Name: __Erica Crenshaw_____ **Date:** __6-21-24_____

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
Pt is a 71 y/o female admitted on 6/14/24 with a diagnosis of Endocarditis of prosthetic aortic valve. Previous medical history includes COPD, Hypotrophic Obstructive Cardiomyopathy, Aortic valve stenosis, Asthma, Calcification of coronary artery, Peripheral artery disease, HTN, HLD, DMII and LV EF was 60% in 2016 with mild aortic stenosis. Previous surgical history of left foot surgery with screw placement to the great toe, fallopian tubal ligation, PCI with stent placement and rotator cuff repair. **Pt was initially admitted on 5/31 to OSH with sepsis secondary to left lower lobe pneumonia with persistent Pseudomonas bacteremia. Transthoracic echo (TEE) and subsequent TEE were initially negative for valve vegetations but repeat TEE showed positive vegetation to the prosthetic aortic valve on 6/12. She is now transferred to the main CCF campus.** **WCCT has been consulted regarding a stage 3 pressure injury on the coccyx. Upon assessment, pt is AOx4, RA, normocephalic with moist mucous membranes, moves all extremities with generalized weakness, incontinent to bowel with no stool noted during assessment by WCCT and incontinent to bladder with an external urine collection device removed by WCCT, no urine noted.** **During WCCT assessment, the stage 3 pressure injury to the coccyx has a full thickness wound with a red and pink hyperpigmented wound bed. The surrounding skin is moist with blanchable erythema. The wound is 7.5cm in length, 8 cm in width and 0.3 cm in depth with**	**Jun 18, 2024 Labs** **<u>BMP</u>** **BUN 15** **Creat 0.95** **Na+ 138** **K+ 4.4** **Cl- 100** **CO2 27** **Ca2+ 8.8** **EGFR 64** **<u>CBC</u>** **WBC 10.55** **RBC 3.95** **Hgb 9.1** **Hct 27.6** **Platelet 211**

a small amount of serosanguineous drainage. MASD was noted on the lower center of the abdomen with redness and maceration to the skin. The WCCT assessment also showed HAI DTPIs to the pt's bilateral heels. Pt reports having complained of pain to the bilateral heels during admission and denies that it was properly addressed or resolved. **<u>Active Medications</u>** **Atorvastatin (Lipitor) 40 mg tabs PO qhs** **Albuterol HFA (Proventil HFA, Ventolin HFA) 90 mcg/ actuation 2 puffs Inhalation q4h prn** **Metoprolol succinate ER (Toprol XL) 150 mg PO daily** **Furosemide (Lasix) 40 mg PO daily** **Aspirin 81 mg PO daily** **Pantoprazole (Protonix) 40 mg PO daily** **Lidocaine 4% patch (Salonpas) Transdermal apply daily** **Lidocaine 4% patch (Salonpas) Transdermal remove daily q12h** **Oxycodone IR 5mg tablets PO q6h prn** **Gabapentin 300 mg PO q12h prn** **<u>Allergies</u>** **Amlodipine *with 5mg doseI*_ Swelling** **Clindamycin_ Itching** **Codeine_ Vomiting** **Darvocet A500_ GI upset, vomiting** **Iodinated Contrast_ GI upset, vomiting** **Shellfish Derived_ Congestion** **Sulfa (Sulfonamide)_ Rash** **Vicodin (Hydrocodon)_ GI upset, vomiting** **Neosporin (Neomycin)_ Rash** **<u>Wound Care Recommendations</u>** **-Monitor Stage 3 PI Full thickness wound for changes in size, depth, color, odor, or visualization of necrotic tissue/ structures such as bone or tendon. Notify WCCT.** **-Change sacral dressing to Full Thickness Stage 3 PI every other day or as needed when soiled. If dressing adheres to wound bed, moisten prior to removal and gently remove.** **-Monitor skin to abdomen for areas of increased erythema, inflammation, irritation or opening of skin. Notify WCCT.** **-Change Antimicrobial Silver+ foam dressing every 3-5 days or when foam is soiled.** **-Monitor bilateral heel DTPIs for changes in size, color, further skin injury, breaks to skin,**	**6/04/24- Chest Radiograph** ***Results:* there is some increased vascular congestion with small effusions. Mild diffuse pulmonary edema. No focal consolidation. No acute rib fractures, pneumothorax or mediastinal shift. Heart is large in size.** **6/12/24- Transesophageal echo with color Doppler study** ***Results:* left atrium is mildly enlarged with no left atrial thrombi or masses noted. Right ventricle is mildly enlarged. No pacer noted. No vegetation not4ed.** ***Impression:* small echo dense mobile mass attached to prosthetic aortic valve noted consistent with vegetation**

or visualization of necrotic tissue. Notify WCCT. **Prevention** **-Ensure bilateral heel protectors are applied and appropriately in place to offload and elevate heels at all times while pt is in bed.** **-Ensure pt remains on a q2h turning schedule using turning positioner/ wedge** **-Manage moisture and continue using low air loss redistribution surface** **-Consult Nutrition for dietary consultation** **-Continue skin prevention interventions based on Braden risk assessment subset scores** **-WCCT will continue to follow pt. Please reconsult for further tissue damage/ skin injury**	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
<u>Stage 3 Sacral Pressure Injury</u> - Present on Admission during this Encounter - Red and pink wound bed - Blanchable erythema & hyperpigmented periwound skin -Wound measurements: 7.5 cmX 8 cmX 0.3 cm -Small amount of serosanguineous drainage with no odor <u>MASD to abdomen</u> - Red, macerated areas to skin and painful to touch -Periwound skin is moist - Scant amount of serosanguinous drainage with no odor <u>Left heel DTPI</u> - Hospital Acquired during this encounter	<u>Stage 3 Sacral Pressure Injury</u> -Cleanse wound gently using low pressure NS flush syringe -Allow area to completely dry -Apply Convatec Aquacel Ag+ dressing to wound bed and cover with an Allevyn sacral foam dressing -Change dressing every other day or as needed when soiled. If dressing adheres to wound bed, moisten prior to removal and gently remove. -Order and apply Medline Comfort Glide Sheet and Turning wedge to off-load pt's coccyx/ ischium -Place pt on a turning schedule and turn pt from right to left q2h. Avoid lying pt on the back for extended periods of time.	<u>Stage 3 Sacral Pressure Injury</u> -Full thickness tissue loss with no eschar or slough present in wound bed or periwound skin. No muscle, tendon or bone present. -Small amount of serosanguineous leakage noted, easily absorbed during cleaning and no saturation to primary or secondary wound dressings. Wound will remain free from any drainage or odor during wound treatment. -No signs of infection demonstrated upon assessment and site will remain infection free during wound treatment as evidenced by an absence of areas with erythema, swelling, pain and tissue damage . -S3 full thickness wound will progress in wound healing as evidenced by formation of new granulation tissue and a reduction in wound size + wound depth -Pt education provided covering significance	<u>Stage 3 Sacral Pressure Injury</u> -Convatec Aquacel Ag+ aides in healing the wound and preventing infection with the use o Ag+ ions and minimizes spaces where bacteria and bioburden could thrive. Contact layer dressings help to maintain a mois and protected wound bed, are minimally adherent, porous, and permit exudate to pass through to the secondary dressing that provides absorption (Jaszarowski & Murphree, 2022). -Allevyn sacral dressing covers and protects wound from external elements while providing a soft cushion to the pressure point. Foam dressings may macerate periwound skin and should be changed before they become overly saturated with exudate. Macerated skin increases the risk of bacterial invasion (Jaszarowski & Murphree, 2022). Thus, the sacral Allevyn dressing should be changed

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-Purple, pink, red intact; non-blanchable tissue & painful to touch -Periwound measurements: 3.5cmx 4.5cmx 0 -No drainage or odor present <u>Right heel DTPI</u> -Hospital Acquired during this encounter -Intact purple, red; non-blanchable tissue & painful to touch -Periwound measurements: 4 cmx 4.5cmx 0 -No drainage or odor present	<u>MASD to abdomen</u> -Place Interdry textile AG sheet to skin fold in a single layer allowing 2-3 inches of overhang to wick moisture. -Order and apply thin layer of Critic-Aid Clear to moist periwound skin. Avoid placing ointment on areas of the skin in contact with the InterDry dressing or on the InterDry dressing itself. -Replace InterDry every 3-5 days or when dressing is soiled (damp is ok) -Replace the external suction device daily or when saturated with urine to prevent build-up of trapped moisture in skin folds or genitalia. -Gently wipe away only the soiled ointment with incontinence cleaning as a means of properly inspecting the skin during assessments -Pt will receive education on routine self-cleansing and protection of the skin against moisture prior to discharge <u>Left heel DTPI</u> -Provide PRN pain medication as needed to alleviate pain -Apply No Sting to affected area on left heel. Leave open to air. -Avoid applying friction or vigorous rubbing to left heel -Order and apply Tru Vue heel protector to left lower extremity to off-load heel while in bed. -Remove heel protector when pt is in shower	of compliance with q2h turning schedule for optimal wound healing. Pt will verbalize understanding and significance of the turn schedule as evidence by willingness and/ or active participation in turns and repositioning q2h <u>MASD to abdomen</u> -Scant amount of moisture to periwound skin, no saturation to worn primary wound dressing noted. -No signs of fungal infection demonstrated upon assessment. Abdominal area will remain free from infection during wound care treatment as evidenced by consistent and appropriate use of listed interventions. <u>Bilateral heel DTPIs</u> -No moisture or odor noted to affected areas of bilateral heels. Bilateral heels will remain free from moisture or odor during the process of wound treatment. -Pt education on significance in maintaining bilateral heel protectors while in bed provided. Pt will have an understanding to the significance of pt compliance as it pertains to ordered interventions as evidenced by no further injury, skin breakage, tears and reduced discoloration noted during wound assessments. -Bilateral DTPIs will not have further tissue loss or deterioration as evidenced by a reduction of repeated scratching, rubbing of frictional force to the bilateral heels following consistent and appropriate use of interventions. -Overall, pt tolerated wound care well and	when there is evidence of moisture or saturatio in order to avoid breakdown of periwound skin <u>MASD to abdomen</u> InterDry AG sheet will significantly reduce episodes of moisture to abdomen, reducing macerated/ red areas and allowing the skin to heal as Ag+ ions transfer to affected area. Changes for the pt acquiring a fungal infection to the affected and moistened area also significantly reduces. The antimicrobial reduces the colonization of bacteria and yeast, such as *S. aureus, S. epidermidis, P.aeruginosa*, & *C. albicans.* The fabric also provides for separation of the folds and the low coefficient of friction (CoF) of the fabric surface protects against skin to skin injury (Gallagher, 2022). Moisture-barrier ointments applied to the perineal and buttocks areas provide protection from both moisture and chemical irritants. The ointment should be applied after initial cleanin and reapplied after each toileting or incontinence episode (Gallagher, 2022). Application of a thin layer of Critic-Aid Clear ointment in particular will also provide the Clinician greater visibility to the skin during skin assessments. <u>Bilateral heel DTPIs</u> Heels should be supported off the surface of th bed and avoid pressure on the tendon or with the use of positioning devices. The goal of redistribution in an individual's care plan is even distribution of pressure and redistribution that shifts pressure concentration from 1 area t another over a period of time (Gallagher, S. & Baranoski, S., 2020). When repositioning in bed, be sure to off-load

	<u>Right heel DTPI</u> -Provide PRN pain medication as needed to alleviate pain -Apply No Sting to affected area on right heel. Leave open to air. -Avoid applying friction or vigorous rubbing to right heel -Order and apply Tru Vue heel protector to right lower extremity to off-load heel while in bed. -Remove heel protector when pt is in shower	was receptive to learning/ education	bony prominences. Rather than relying on repositioning with pillows under the pt's shoulders and hips, the pt should be turned sufficiently to avoid areas of potential pressure (Gallagher, S. & Baranoski, S., 2020). Identification of DTPIs in pts with darker complected skin is significant as it pertains to the avoidance of HAIs. Clinicians performing skin checks should be instructed to: ● Moisten the skin ● Inspect for changes in pigmentation ● Palpate for edema ● Ask about pain the area ● Use indirect light to examine skin (Edsberg, 2022; Black, 2018) It should be noted that moistening areas prone to DTPIs prior to inspection visualize and typically distinguish a DTPI or Staged PI from uninjured skin.

References:

Black, J. (2018). Using thermography to assess pressure injuries in patients with dark skin. *Nursing*. 48(9), 60-61.

Edsberg, L. (2022). Pressure and Shear Injuries. In L. McNichol, C. Ratliff, S. & Yates. (Eds.), *Wound, Ostomy and Continence Nurses Society care curriculum: Wound management* (2nd ed., pp 373-390). Wolters Kluwer.

Gallagher, S. (2022). Skin and Wound Care for the Bariatric Population. In L. McNichol, C. Ratliff, S. & Yates. (Eds.), *Wound, Ostomy and Continence Nurses Society care curriculum: Wound management* (2nd ed., pp 279-290). Wolters Kluwer.

Gallagher, S. and Baranoski, S. (2020). Adiposity and the Bariatric Patient. In S. Baranoski & E. Ayello (Eds.), *Wound core essentials: Practice principles* (5th ed., pp 618-630). Wolters Kluwer.

Jaszarowski, K. & Murphree, R.W. (2022). Wound Cleansing and Dressing Selection. In L. McNichol, C. Ratliff, S. & Yates. (Eds.), *Wound, Ostomy and Continence Nurses Society care curriculum: Wound management* (2nd ed., pp 157-182). 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: _____