WOC Complex Plan of Care

Name: ____Nancy Ndamukong_____ Patient Encounter Date: _09/18/2024_____

Preceptor for Patient Encounter: ___Helen Shubsda_____

Clinical Focus: Wound **_yes___** 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
Patient is a 33 y/o female, seen with the admitting diagnoses of cryptococcal meningitis. She is being treated by the primary team. WCCT was consulted to assess wound to the right breast and left hip present on admission. Patient has known history of Breast disorder cyst, erythema nodosum postpartum, hidradenitis, pyoderma gangrenosum, necrotizing fasciitis to RLE and prednisone induced diabetes. Surgical history of: I&D abscess complex/multiple. Patient states at home, she uses Vaseline and ABD pad to manage the dressing. She stated that she uses the Vaseline because everything stick to her skin.	**Labs**: WBC on admission 27.87, trended to peak 38.92. Persistent leukocytosis at 24.25. Hgb 9.8 (range 9-10). AST 168. **Diagnostic test results**: DVT US; negative. Abdominal US; negative. CT of the brain; within normal limit

Assessment	Plan/Interventions/ Alternatives	Evaluation	Rationale
Patient seen today for open non-healing wound	o Stop	❖ Proper wound management,	o Patient was stopped from

caused by hidradenitis on the right breast and left hip. Medication was reviewed, patient is on prednisone, antifungal medication, she completed antibiotics prior to admission. Lab results show increased glucose level of 153. Patient reported treating wound at home with Vaseline and covering it with ABD. Patient laying down in bed, agreed on dressing change to be done at this time. Complaint of pain to the wound site. Old dressing gently removed by patient as requested, both wounds cleaned with NS and pat dry. Wound #1 left hip wound (since 09/09/2024): moderate drainage (serosanguineous), 100% granulation tissue, wound edge attached to wound base, no erythema present in the peri-wound. Photo and measurement taken. Wound measures 1.5 cm long x1.5 wide cm x 0.3 cm deep. Adaptic (Oil emulsion) dressing applied to wound, covered with bordered foam (allevyn). Wound #2 is the right breast wound (since 08/30/2024): moderate drainage (serosanguineous), 100% granulation tissue, wound edge attached to wound base, no erythema present in the peri-wound. Photo and measurement taken. Wound measures; 1 cm long x 1.5 cm wide x 0.3 cm deep. Adaptic (Oil emulsion) dressing applied to wound, covered with allevyn. Patient tolerated well. Braiden assessment completed: Patient scored a 4 on sensory perception; she has no limited ability to feel or express concern. 4 on moisture, she is continent and uses bedside commode with the assistance of a nurse. 3 on	using Vaseline and ABD pad to your wound. o Clean wound with a non-cytotoxic wound cleanser (vashe), pat dry and apply an Adaptic (oil emulsion) dressing, then cover with bordered foam (allevyn). o Change dressing daily after taking a a bath. o Consider smoking	dressing and cleaning has helped to keep the wound free from s infection. No redness or increased pain/drainage present in the wound and the peri-wound. ❖ Smoking cessation has helped the wound to decrease in size. ❖ Tapering prednisone and nutritional changes has helped reduced blood sugar. ❖ Placing the head of bed at 30 degree ankle has aided in keeping patient free from developing friction and shear. ❖ Patient requires more physical therapy intervention to be able to walk independently.	using Vaseline and ABD pad because Vaseline is not an antiseptic and could cause infection to the wound. ABD pad is not really required for this wound since it is not a highly exudate wound. o Wound should be cleaned with non-cytotoxic solution because it will not kill the cells in the wound and prevent wound from healing. Adaptic helps to prevent the wound from sticking and the allevyn gives it a protective cushin. o Dressing should be changed daily after taking a shower because the wound is a part of your body and you have to keep it clean as well. o Smoking cessation should be considered because nicotine is a vasoconstrictor which may prevent the vessels and prevent blood flow to the wound. Thus, impeding proper wound healing. o Consulting a dietitian will

activities as she can walk to the bedside commode, but she also spend most of her days in bed and on the bedside chair. 4 on mobility, patient is able to turn herself and move up in bed without assistance. Nutrition wise, she scores a 3 as she eats over half of most meals. 2 for friction. Patient can move self in bed with a minimal assistance, but sliding self in bed as she does could lead to friction. Totally, patient get a Braden score of 20.	cessation, and weight loss. o Consult a dietitian for diabetic diet o Wear loose clothes to avoid friction to the affected are o Washe affected area with antiseptic solution to prevent bacteria growth. o Keep good hygiene o Consider using topical and systemic		guide the patient on making good nutritional choices. Thus, helping with blood sugar control. o Wearing loose clothes to the affected area will help reduce friction and also help to prevent further skin damage. o Using antiseptic soap with good hygiene will help to kill some bacteria on the skin. This will prevent wound infection. o If all the interventions fail, it is highly recommended to consider topical and systemic antifungal and antibacterial treatments. o Tapering prednisone will help decrease blood sugar level and also enhance wound healing. o Physical therapist intervention will help patient being able to gain muscle strength and start ambulating out of the room. o Giving patient snack at bed time will help regulate blood sugar through out the night. Thus, helping

	antibiotics and antifungal agents if the above mentioned plans fail. o Consider tapering down prednisone (Prelone) to decrease blood sugar level. o Physical therapy to evaluate and treat o Offer patient snack before bedtime o Put head of bed at 30 degree angle o Next		with wound healing. o Placing the head of bed at 30 degree will help prevent patient from sliding down in bed. Thus, preventing friction shearing of the skin against the sheet.

	follow up in one week. o **Alternatives** Patient treatment/ dressing option was changed from Vaseline and ABD pad to oil emulsion and allevyn. Based on the moderate drainage, i would have recommended the use of silva alginate and allevyn to aid in		

	wicking the wound and promote healing. But this product is not available in the units and would be a special order for the unit. So, the treatment option used here is based on what is available in the units.		

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. 397- 419). 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: _____