**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 12.8, Persistent leukocytosis at 24.25. Hgb 9.8 (range 9-10). AST 168.<br>**Diagnostic test results**:<br>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 caused by hidradenitis on the right breast and left hip. | Stop using Vaseline and | ❖ Proper wound management, | o Patient was stopped from using Vaseline and ABD |

**WOC Complex Plan of Care**

| | | | |
|---|---|---|---|
| Medication was reviewed, patient is on prednisone, antifungal medication, she completed antibiotics prior to admission. Lab results show increased glucose level of 153.<br>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 per policy. 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 per policy. 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.<br>**Braiden scale score for pressure risk assessment completed**<br>Patient scored a 4 on sensory perception; she has no limited ability to feel or express concern.<br>4 on moisture, she is continent and uses bedside commode with the assistance of a nurse. 3 on 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 | ABD pad to your wound.<br>o Clean wound with warm compress, pat dry and apply an Adaptic (oil emulsion) dressing, then cover with bordered foam (Allevyn).<br>o Change dressing daily.<br>o Stop smoking.<br>o **Nutrition:** Consult a dietitian for diabetic diet<br>o Avoid friction rub by wearing loose cloth.<br>o Wash affected area with soap and water daily.<br>o Wash hands with soap and water before and after each dressing change.<br>o Decrease blood | dressing and cleaning helps to keep the wound free from infection. No redness or increased pain/drainage present in the wound and the peri-wound.<br>❖ Smoking cessation promote healing environment.<br>❖ Tapering prednisone and nutritional changes help reduced blood sugar.<br>❖ Placing the head of bed at 30 degree ankle helps keep patient from sliding down in bed and developing friction and shear.<br>❖ Patient requires more physical therapy | pad because Vaseline is not an antiseptic and could cause infection to the wound. ABD pad is not highly recommended (Andrus, 2023) for this wound since it is not a highly exudate wound.<br>o Wound should be cleaned with warm compress (Andrus, 2023) because it is highly recommended by dermatologist as it prevent bacterial growth. Adaptic helps to prevent the wound from sticking and the allevyn gives it a protective cushion.<br>o Changing dressing daily will help decrease bacterial growth and odor.<br>o Nicotine caused vasoconstrictor which may prevent the vessels and prevent blood flow to the wound. Thus, impairing the skin from healing and regenerating (Tan, 2024).<br>o Consulting a dietitian will guide the patient on making good nutritional choices. Thus, helping with blood sugar control. |

| | | | |
|---|---|---|---|
| she eats over half of most meals. 2 for friction/shear. 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 (Borchert, 2022). | sugar level by tapering down prednisone (Prelone).<br><br>o **Activities:** Physical therapy - evaluate and treat.<br>o Offer patient snack before bedtime<br>o **Friction/shear**: Put head of bed at 30 degree angle.<br>o Next follow up in one week.<br>o Attache Stryker Procuity pump to patient's mattress.<br>o Routine follow up with dermatologist every six months.<br><br>**Alternatives**<br>Patient treatment/dressing option was | intervention to be able to walk independently. | o Wearing loose clothes to the affected area will help reduce friction and also help to prevent further skin damage (Andrus, 2023).<br>o If all the interventions fail, it is highly recommended to consider topical and systemic antibiotic and anti-inflammatory (Agbai, & Nyanda-Manalo, 2023) treatments.<br>o "Physical activities has a positive impact on functional outcome" (Ohtsubo, 2023). It will help patient to gain muscle strength and start ambulating out of the room.<br>o Giving patient snack at bed time will help regulate blood sugar through out the night. Thus, helping with wound healing.<br>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 |

| | | | |
|---|---|---|---|
| | 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. Other alternatives include Mepilex, foam dressing, antimicrobial dressings such as Acticoat, and Aquacel Ag. Zinc oxide cream, Visk vapor rub. Bleach bath, and Epson salt bath. | | against the sheet. |

**References:**

Agbai, O., Nyanda-Manalo, L., & Fyfe, S. (2023). Treatment Disparities in Patients of Color With Hidradenitis Suppurativa. *Dermatology Times*, *44*(4), 26–27. https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=rzh&AN=162991003&site=ehost-live

Andrus, E. (2023). Are You Counseling Your Patients With HS About Proper Wound Care? *Dermatology Times*, *44*(9), 62. https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=rzh&AN=171904523&site=ehost-live.

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.

Ohtsubo, T., Nozoe, M., Kanai, M., & Ueno, K. (2023). Physical Activity as Measured by Accelerometers Predicts Functional Improvement in Older Patients Undergoing Hospital Rehabilitation. *Journal of Aging & Physical Activity*, *31*(4), 651–657. https://doi.org/10.1123/japa.2022-0189

Tan, I. (2024). E-Cigarettes and Vaping: Clinical Implications of Dermapathology, Impact on Atopic Dermatitis. *Dermatology Times*, *45*(6), 14–15. https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=rzh&AN=177649045&site=ehost-live

**WOC Complex Plan of Care**

| 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:**<br>Using the Braden scale, assess for pressure injury risk.<br>**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.<br>**Wound and Continence Case Study Journal:**<br>Include specific Braden sub-scale scores | 12 | *8* | *See my comments throughout* |
| | Propose alternative products. Include generic & brand names | 4 | *2* | *This is done for some* |
| **Evaluation** | Identify plan of care evaluation parameters that demonstrate the desired outcomes | 6 | *5* | *This is present for some POC points* |
| **Rationale** | Explain the rationale for identified interventions | 6 | *3* | *See my comments- these need to be backed with EBP foundational sources.* |
| **Scholarly work** | Rationales referenced & cited according to APA formatting guidelines | 1 | *0* | *See requirements* |
| | Proper grammar & punctuation used | 1 | *1* | |
| | References:<br>See the course syllabus for specific requirements on references for all assignments | 1 | *0* | *See requirements* |
| | **Total Points**<br>80 % or higher is required to pass.<br>Minimum scores: Ostomy: 36/45<br>Wound and Continence: 40/50 | | *38/50* | |

**Additional comments:**

*Hi Nancy – see my comments throughout this complex care plan assignment. As the 80% threshold was not met on this assignment, it is eligible for resubmission to try to recoup lost points. Make sure your sources are used*

*and cited appropriately. There is no specific due date for these update, it can be turned back into the drop box whenever completed. Reach out with any further questions.*

Reviewed by: _Mike Klements 9/19/24____ Date: 9/19/24