

## WOC Complex Plan of Care

Name:     Nancy Ndamukong     Patient Encounter Date:   09/20/2024  

Preceptor for Patient Encounter:   Bate, Heather  

Clinical Focus: Wound      Ostomy   YES   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
<p>This is a 73 y/o female who presented with complaint of fecal incontinence and Paget’s disease of the anal canal and vulva. She has a past medical history of HTN, hyperthyroidism, obesity, DVT, anemia, and restless leg syndrome. She denies fever, chills, chest pain and SOB. Past surgical history include; ileostomy, knee replacement, lumbar fusion, trach. and G-tube placement due to COVID, anal biopsies and ileostomy reversal with hernia repair. A robotic laparoscopic colostomy was created. The examination was done under anesthesia rectal sigmoidoscopy flexible. A loop sigmoid colostomy was created to LLQ of the abdomen.</p>	<p>Patient’s pertinent lab results looks normal except for a slight elevation in creatinine. Platelet count 296, WBC 7.88, Na 141, K 4.2, Crt 1.10 (Norm. 0.58- 0.96), Hgb 10.2 EKG was normal. Tissue biopsy obtained from the skin around the anus, result pending.</p>

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
<p>This was a post operative initial visit. Patient seen for Rod removal, Pouch</p>	<p>❖ To change a disposable two-piece pouch with cut</p>	<p>❖ Prior to beginning changing a pouch, it is important to</p>	<p>▪ Gathering the supplies before beginning pouch</p>

### WOC Complex Plan of Care

<p>system change and education. Met patient at bedside, just back from a walk and she agreeable to lesson, pouch change and half Rod removal. Patient stated she had an ileostomy approximately two years ago and used a one piece pouch system. Her husband helped her with changes. She stated that her ileostomy was in the crease and had a lot of leakage. We discuss the differences between ileostomy and colostomy, GI anatomy reviewed and reviewed how to order supplies. Pamphlet given, diet and hydration after bowel surgery discussed. Patient will like a visit and teaching with the husband. He is coming from Columbus tomorrow.</p>	<p>to fit barrier flange, First wash your hands with soap and water. Gather the following supplies:</p> <ul style="list-style-type: none"> <li>- Washcloth or soft paper towels e.g Bolt, bounty, Scott or brawny.</li> <li>- Scissors with at least one blunt tip.</li> <li>- Plastic bag for waste.</li> <li>- New pouch: Hollister New Image drainable 2 ¼” pouch.</li> <li>- Skin barrier flange: Hollister New Image Ceraplus convex 2 ¼”</li> <li>- Accessary products: adhesive removal, and barrier ring.</li> </ul> <p>❖ Prepare the new pouch:</p> <ul style="list-style-type: none"> <li>- measure the flange and trace the pattern (size to fit within 1/8” away from the stoma).</li> <li>- Cut out the skin barrier flange</li> <li>- Center the pouch opening over the skin barrier flange and snap firmly together.</li> <li>- Close the end of the pouch.</li> <li>- Remove the skin</li> </ul>	<p>identify all the necessary supplies, gather them together and bring them to the bedside. This helps in reducing the risk for cross contamination and infection by minimizing exposure to bacterial.</p> <ul style="list-style-type: none"> <li>❖ Prepare the new pouch by measuring and cut to fit (1/8” away from the stoma) before starting the process of removing the worn pouch, is to ensure proper fit of the new flange, reducing risk of skin irritation and leakage.</li> <li>❖ A clean and dry peristomal skin with the application of no sting skin prep will facilitate the adhesion of the flange tape to the skin.</li> <li>❖ Applying a pouch and holding it with the palms for few minutes helps provide a better seal.</li> <li>❖ Placing the head of bed at 30 degree angle helps keep patient from sliding down in bed and developing friction and shear.</li> <li>❖ Patient requires more physical therapy intervention to be able to walk independently.</li> </ul>	<p>change (Blevins, 2019) helps in reducing the spread of bacterial and contamination. Such planning also ensure patient’s safety, comfort and effective care delivery.</p> <ul style="list-style-type: none"> <li>▪ Measuring and cutting the new flange to a proper fit helps in monitoring the stoma size and shape changes and adjust care plan accordingly.</li> <li>▪ A clean and dry peristomal skin enhances flange adhesion, reducing risk of leakage, and to “avoid changes in PH level of the skin” (Blevins, 2019). No sting skin prep protects the skin from moisture damage.</li> <li>▪ To apply a pouch over the stoma and “press it down” (Blevins, 2019) with the palms of your hand for few minutes helps allow for moldability of pouch seal around stoma.</li> <li>▪ Placing the head of bed at 30 degree will help prevent patient from sliding down in bed. Thus, reducing the risk of pressure injury from</li> </ul>
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### WOC Complex Plan of Care

<p>barrier placed right around the stoma, and attached to drainable pouch.</p> <p>Braden score pressure injury assessment completed:</p> <p>Patient scored a 4 on <b>sensory perception</b>; she has no limited ability to feel or express concern.</p> <p>Patient scores a 3 on <b>moisture</b>, her stool is contained in the pouch but she occasionally experience urinary incontinence before the staff assist her to the toilet. She scores a 2 on <b>activities</b> as she is obese and cannot bear her own weight. She can only be assisted to the wheelchair by the staff.</p> <p>3 on <b>mobility</b>, patient is able to slightly move herself up in bed without assistance. <b>Nutrition</b> wise, she scores a 4 as she eats and finish all her food and always requesting for snacks. She scores a 2 on <b>friction and shear</b>. 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 18 (Borchert, 2022).</p>	<p>barrier cover papers from the adhesive surface of the flange.</p> <ul style="list-style-type: none"> <li>- Set the prepared pouch assembly aside, with sticky site up.</li> </ul> <ul style="list-style-type: none"> <li>❖ Carefully remove the worn pouch and discard. Use adhesive removal as needed.</li> <li>❖ Clean the skin around the stoma with warm water (no soap) and soft paper towel. Rinse and pat dry. Apply skin barrier and let it dry.</li> <li>❖ Apply the prepared pouch by centering it over the stoma and press into place. Smooth the sticky surface of the skin barrier flange onto the skin. Hold the pouch in place for few moments.</li> <li>❖ Notify the physician if experiencing diarrhea or loose stool for more that 5-6 hours (Belvins, 2019).</li> <li>❖ Notify MD if there is no output within 4-6 hours in addition to cramping and nausea.</li> <li>❖ Empty colostomy pouch when it is 1/3-1/2 full and at bed time.</li> </ul>	<ul style="list-style-type: none"> <li>❖ Changing the colostomy pouching system every 3 to 7 days helps reduce skin irritation, prevents bacterial growth and odor.</li> <li>❖ Patient emptying pouch when it is 1/3 – 1/2 full and at bed time with no difficulties.</li> <li>❖ Patient monitored for diarrhea or watery stool. Non present for this patient.</li> <li>❖ Fecal Output monitored, amount of effluent is normal. No cramping or nausea present.</li> <li>❖ Patient turned every 2 hours has a low risk of developing pressure injury.</li> </ul>	<p>sliding and friction.</p> <ul style="list-style-type: none"> <li>▪ Physical therapist intervention promotes functional mobility and independence. Gaining strength will help patient to be able to transfer from bed to wheelchair.</li> <li>▪ The importance of changing a colostomy pouch regularly is to maintain skin integrity, prevent complications and promote patient comfort and safety.</li> <li>▪ Emptying the pouch when it is 1/3-1/2 full and at bed time (Blevins, 2019) is helpful in that the pouch do not get heavy and pull away from the skin. Emptying before bedtime helps the patient to sleep without being worried of the pouch getting full.</li> <li>▪ Having diarrhea or watery stool for more that 5-6 hours places patient at the risk of dehydration and electrolyte imbalance which can also lead to other health complications (Blevins, 2019).</li> <li>▪ No output within 4-6 hours</li> </ul>
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### WOC Complex Plan of Care

	<ul style="list-style-type: none"> <li>❖ Change pouching system every 3-7 days or if leaking occur and assess skin integrity (Belvis, 2019). <b>Braden sub-scale score deficit</b></li> <li>❖ Moisture: Assist patient to the bathroom every 4 hours.</li> <li>❖ Activity: Physical Therapy evaluate and treat.</li> <li>❖ Mobility: Reposition patient every 2 hours per facility policy (Higgins et al., 2020).</li> <li>❖ Attache stryker Procuity air pump to patient’s mattress.</li> <li>❖ Friction/shear: Put head of bed at 30 degree angle when patient is sitting up in bed.</li> </ul> <p><b>Alternatives:</b> Some alternatives to Hollister New Image drainable 2 ¼” pouch include but not limited to:</p> <ul style="list-style-type: none"> <li>○ ConvaTec Sur-Fit Natura Drainable Pouch 2 1/4" (8577).</li> <li>○ Coloplast Assura Drainable Pouch 2 ¼ inch (4131).</li> </ul>		<p>associated with cramping and nausea is a possible indication of blockage, and requires physician’s intervention (Blevins, 2019).</p> <ul style="list-style-type: none"> <li>▪ The rate of pressure injury reduces when a patient is turned every 2 hours because</li> <li>▪ Turning patient every 2 hours helps take off pressure from the contact point, thus reducing pressure injury (Higgins et al., 2020).</li> </ul>
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### WOC Complex Plan of Care

	<ul style="list-style-type: none"> <li>o Cymed Microskin Drainable Pouch 2 1/4" (MSC230).</li> </ul> <p>Alternatives for Hollister New Image Ceraplast convex 2 1/4" skin barrier Flange.</p> <ul style="list-style-type: none"> <li>o Conva Tec Sur-Fit Natura Convex Light Touch Barrier 2 1/4 inch (8575).</li> <li>o Coloplast Assura Convex Barrier 2 1/4 inch (4135)</li> <li>o Cymed Microskin Convex Barrier 2 1/4 inch (MSC230CV).</li> </ul>		
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**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.

Blevins, S. (2019). Colostomy Care. *MEDSURG Nursing*, 28(2), 125–126. <https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,cookie,url,uid&db=rzh&AN=135960899&site=ehost-live>

Higgins, J., Casey, S., Taylor, E., Wilson, R., & Halcomb, P. (2020). Comparing the Braden and Jackson/Cubbin Pressure Injury Risk Scales in Trauma-Surgery ICU Patients. *Critical Care Nurse*, 40(6), 52–61. <https://doi.org/10.4037/ccn2020874>

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Content	Possible Points	Awarded Points	Comments
<b>Summary of Selected Patient</b>	Summarizes pertinent medical and surgical history	2	
<b>Assessment</b>	Describe assessment findings	6	
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	6	
	<b>Wound and Continence Case Study Journal:</b> Using the Braden scale, assess for pressure injury risk. **You must submit your completed Braden risk assessment with your care plan.	5	
<b>Planning</b>	Formulate a comprehensive management plan based on the assessment and the specialty (wound, ostomy, or continence) needs. <b>Wound and Continence Case Study Journal:</b> Include specific Braden sub-scale scores	12	
	Propose alternative products. Include generic & brand names	4	
<b>Evaluation</b>	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	
<b>Rationale</b>	Explain the rationale for identified interventions	6	
<b>Scholarly work</b>	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	
	<b>Total Points</b> 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50		

**Additional comments:**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_