WOC Complex Plan of Care

Name: ___Patricia Weimer_____ **Patient Encounter Date:** _Thursday 9/19/2025_____

Preceptor for Patient Encounter: ___Jeanine Osby_____

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
17-year-old male with history of gunshot wound March 2024 resulting in C5-C7 spinal cord injury, causing quadriplegia, diaphragm dysfunction with chronic respiratory failure, trach/vent dependency, and neurogenic bladder. Current admission (7/21/2024) for pulmonary embolism and stage IV pressure injury wound to sacrum. WOCN consult for initial NPWT application 9/19/2024. Wound has 98% red, moist tissue with 2% adherent slough tissue. Wound edges are flat, even, and without epibole. Periwound skin with purple hue from 11 to 4 o'clock with thin rim of mixed white and red tissue from 7 to 10 o'clock. Unable to assess previous drainage from Hydrofera Blue dressing. **Wound Measurements:** 6.5 cm x 5.0 cm x 2.3 cm with 1.5 cm undermining at 12 o'clock and 1.0 cm undermining at 6 o'clock.Wound vacuum (NPWT) placed to sacral wound 9/19/2024.	**WBC** **HGB** **HCT** **Platelets** **Neutrophils** **Sodium** **Potassium** **Chloride** **Protein** **Albumin** **Calcium** **Glucose** **BUN** **Creatinine** **Prealbumin** **HgbA1C**

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Tubes/Drains: G-Tube in place for feeding overnight. PO during the day. Condom catheter in place to collect urine and monitor output Trach 6.5 Shiley: cuff inflated with 1.5 ml in daytime, 2 ml at night to improve volumes **Neurological/Pain** Tylenol 650 mg PO/GT Q 6 hr PRN pain. Celecoxib 200 mg 1 capsule PO/GT BID Gabapentin 700 mgs PO/GT TID Zanaflex 2 mg PO/GT q8hr Seroquel 25 mg PO/GT QHS Melatonin 6 mg PO/GT QHS Lidocaine patches to neck, shoulder, arm (12hr on/12 hr off) K pad Q 4hr for pain **Respiratory:** Trach 6.5 Shiley: cuff inflated with 1.5 ml in daytime, 2 ml at night to improve volumes SIMV-PC: Resp. 14, PEEP 8, PC 24, PS 16, 2L O2 iTime 1.0 Albuterol Inhaler TID and PRN Nebusol TID Inhaled Tobramycin for history of Pseudomonas colonization of trach (Two weeks on/Two weeks off) Currently on – stop 10/2 IVP + cough Assist TID and PRN Maintain HOB at 30 degree angle at all times. **Hematology:** Xarelto 20 mg PO/GT daily (no need to recheck labs) **GI:** Regular diet during the day, encourage PO 3 meals and 2 snacks. Encourage increased fluids to 1.5 L PO Limit salty foods and sugary drinks Overnight Tube feeds: Impact Pediatric Peptide 1.5 L at 102 ml/hr for 10 hours overnight with 80 grams beneprotein 120 ml water flush at beginning and end of feeds (total 240 ml)	**Culture:** Tracheostomy culture: from LTACH + Candida arius (6/21/24) – contact precautions indefinitely + MRSA (6/13/24) Urine Culture: + pseudomonas 8/20/24 (S/P Levaquin 8/20 – 8/24)

Cyproheptadine 8 mg PO/GT QHS Protonix 40 mg PO/GT daily Colace 100 mg PO/GT BID Senna 8.6 mg PO/GT daily Miralax 17 gram PO/GT daily Monitor BM output Weigh Q Monday **Cardiovascular:** Continuous cardiorespiratory monitor Q 2hr vitals Midodrine 2.5 mg PO/GT BID **Renal:** Strict I&Os Maintain condom catheter. If no output in 8 hours – bladder scan, straight cath if > 300 ml Infectious Disease: Monitor temperature; if fever again, full sepsis work-up **Rehab/Social:** Last Family meeting 7/26/2024 – escalation plan discussed for any further threats (Workplace violence, direct channel to security, filing report, contacting ombudsman) Increased security will be called to monitor non-family visits. Time pulmonary treatments and medication administration window to allow for more patient autonomy	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
1. Stage IV pressure injury wound to sacrum Braden Score Sensory Perception – Limited (1) Moisture – Moist (2)	1. Weekly NPWT dressing removing and replaced. Remove drape and sponge dressing to sacral wound.	1. NPWT is in place and functioning.	1. Negative pressure wound therapy (NPWT) has been widely used in the treatment of pressure ulcers (Shi et al., 2023)

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Activity – Chairfast (2) Mobility – Slightly Limited (3) Nutrition – Adequate (3) Friction and Shear – Problem (2) Total: 13 – High Risk for Skin Breakdown Note: Existing pressure injuries automatically makes patient very high risk for pressure injuries.	Cleanse periwound area with soap and water. Irrigate with normal saline. Measure and access wound bed and document. Prep periwound area with skin prep, allow to dry, and apply protectant layer of transparent drape (include area to bridge) Fill wound with one piece of black foam and use one piece of black foam to bridge to left hip (alternate bridge sites with each dressing change.) Total: 2 pcs black foam. Cover black foam with transparent drape, cut nickle size opening for trac pad and apply trac pac. Connect to 125 mmHg suction. Write date/time/# of foam pcs on drape. Empty collection canister daily and document output, quantity and quality.	Wound will decrease in size. Wound bed will fill with granulation. No dressing remnants are left in wound bed. Suction remains at 125 mmHg Dressing is changed Q 7 days and no foam remnants are left in wound bed. Documentation of drainage is recorded in patient record. Volume of exudate is compared.	NPWT may speed up the reduction of pressure ulcer size and severity of pressure ulcer, reduce pain, and dressing change times (Shi et al., 2023). Sealing of the wound via dressing drape protects it from external contamination and creates a moist and warm environment (Agarwal, 2022). Suction of the wound bed removes fluid with inflammatory mediators and cytokines that prevent proper wound healing (Agarwal, 2022). NPWT removes edematous fluid and exudates aiding in the healing process. The microenvironment improves. All of these effects help promote wound healing, with

			increased blood flow and granulation tissue formation, cell proliferation, a reduction of inflammation, and bacterial load in the wound (Agarwal, 2022).
2. High Risk for nonhealing of current wound and pressure injury to additional areas.	2. Staff will maintain every two hour turning/repositioning to off-load sacrum ischium.	2.Turning record will be recorded in patient's chart.	Repositioning is an integral component of pressure ulcer prevention and treatment; it has a sound theoretical rational (Gabison, et al., 2022)
	Reinforce the importance of off-loading with patient each shift. Use age-appropriate terms	Patient states understanding of off-loading sacrum with wedges, turning, repositioning to assist in wound healing.	
	Maintain Dolphin Fluid Immersion bed without fitted sheet. Using flat sheet only.	Maintain Dolphin Fluid Immersion bed is in place with flat sheet only.	Dolphin therapy surface maintains blood flow and tissue perfusion by more evenly redistributing pressure, thereby eliminating high pressure points, reducing tissue deformation, and improving wound healing. The mattress is designed to reduce pressure across the body, maintain an appropriate microclimate and to promote patient comfort (Fletcher, n/d).
	Encourage patient to reposition self, reinforcing rational. Using age-appropriate explanation.	Patient assists in repositioning/off-loading as his condition allows, using upper body strength.	
	Maintain Tru-Vue heel protectors to prevent heel breakdown.	Tru-Vue heel protectors remain in place while patient is in bed and heels remain intact without redness.	
3. Incontinent of stool and urine.	3. Bathe patient and maintain clean bed environment daily and PRN. Apply pH-balanced	3. Skin remains clean and intact, without redness or breakdown.	

	moisturizer to skin with bath and PRN. Maintain condom catheter in correct position. Maintain clean peri area using chux or depend		
4. High risk for shear or friction Skin damage versus high risk for high risk of aspiration of contaminated oropharyngeal secretions with subsequent development of vent-associated pneumonia.	4. Head of the bed must be maintained at 30 degrees. Not higher to prevent friction/shear. Not lower to prevent vent-associated pneumonia.	4. Head of bed remains at 30 degress. Patient maintains skin integrity without shear or friction damage. Patient maintains lung function without developing pneumonia.	Sealing of the wound via dressing drape protects it from external contamination and creates a moist and warm environment (Agarwal, 2022).
5. High risk for psychosocial stressors with potential for developmental delay. Adolescence (age 12-18) Identity versus confusion. Adverse Childhood Experiences (ACEs) including Household Dysfunction: incarcerated relative, divorce, and uninvolved parent. Neglect: emotional Pre-gun shot history of ADHD, anxiety & depression.	Staff interaction with patient will incorporate Trauma-Informed Care and take into consideration the patient's developmental stage. All staff interacting with patient will: Assist patient to get out of his room at least once per week, more frequently as staffing allows. Respond with compassion and empathy to feelings	Patient exhibits calm and constructive behavior. Patient participates in self-care and therapy. Patient agrees to leave his room when staff are available to assist. Patient expresses feelings and frustration in less threatening speech.	

	Give patient control/options when possible. Narrate what patient is feeling. Examples: "I know you didn't expect to be here this long and this is frustrating." "You are angry. I'm sorry we have to turn you so often." Redirect negative behaviors. Ignore swearing/name-calling. Never threaten. Avoid negative consequences or "taking things away". Set boundaries. Praise actions you want to see more of.	Patient expresses feelings of having control over more aspects of his life. Aggressive behaviors decrease in frequency.	Research supports that adverse childhood experiences (ACEs) are common, impact the developing brain, and are associated with subsequent negative health, social, and life outcomes.6,7,9 To address the public health crisis of childhood trauma, pediatric physical therapists must join our colleagues across disciplines to holistically care for children and their families using a trauma-informed care (TIC) approach (Barreca & Swiggum, 2024). Children with developmental disabilities may lack well-

			developed self-regulation ability, a sense of mastery, and self-efficacy —all of which can hinder their ability to develop resilience (Barreca & Swiggum, 2024). The effects of trauma and secondary trauma on the body and mind can be devastating with long-term outcomes that limit participation in life, physical health, and well-being. …advocate at all levels for practices and policies that minimize trauma and build resilience in the children and families we serve and in ourselves (Barreca & Swiggum, 2024).

References:

Agarwal A. (2022). Evolution of Negative Pressure Wound Therapy in Orthopaedic Trauma. Journal of orthopaedic trauma, 36(Suppl 4), S1–S5. https://doi-org.foyer.swmed.edu/10.1097/BOT.0000000000002431

Barreca, J., & Swiggum, M. (2024). Trauma-Informed Care in Pediatric Physical Therapy as a Standard Precaution: The Time Is Here. Pediatric Physical Therapy: the official publication of the Section on Pediatrics of the American Physical Therapy Association, 36(2), 278–284. https://doi-org.foyer.swmed.edu/10.1097/PEP.0000000000001095

Fletcher, Jacqui, Wounds UK; Fellow, NICE; Clinical Strategy Director, Welsh Wound Innovation Centre, UK

Shi, J., Gao, Y., Tian, J., Li, J., Xu, J., Mei, F., & Li, Z. (2023). Negative pressure wound therapy for treating pressure ulcers. The Cochrane database of systematic reviews, 5(5), CD011334. https://doi-org.foyer.swmed.edu/10.1002/14651858.CD011334.pub3

Gabison, S., Pupic, N., Evans, G., Dolatabadi, E., & Dutta, T. (2022). Measuring Repositioning in Home Care for Pressure Injury Prevention and Management. Sensors (Basel, Switzerland), 22(18), 7013. https://doi-org.foyer.swmed.edu/10.3390/s22187013

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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: _____