WOC Complex Plan of Care

Name: _____Patricia Weimer_____ **Patient Encounter Date:** _____10/2/2024_____

Preceptor for Patient Encounter: _____Helen Shubsda_____

Clinical Focus: Wound ____ Ostomy ____ Continence _X___

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
63-year-old male with history of cirrhosis, NASH (nonalcoholic steatohepatitis), peripheral vascular disease, cerebral vascular accident with residual right-sided weakness, diabetes, and hypertension. Additional comorbidities include Stokes-Adams episodes and hepatic encephalopathy. History of back and neck surgery with continuing chronic back pain. Liver transplant 8/19/2024, (Day + 44). Sacrum has developed MASD/IAD (Moisture-Associated Skin Damage/Incontinent-Associated Dermatitis). **Pain Medications**: Lidocaine patch – apply to skin of right low back (Alternate on/off Q 8 hours) Tylenol 500 mg liquid via NG/CORPAK PRN Q 4 H Oxycodone 5 to 10 mg liquid via NG/CORPAK PRN Q 4 H Robaxin 500 mg PRN TID via NG/CORPAK **Glucose Management:** Insulin Lispro 8 units subcutaneous 3 times QD (rapid-acting)	WBC 18.56 (high) RBC 2.51 (low) Hemoglobin 7.5 (low) Note: T&S drawn 10/1 Hematocrit 24 (low) Platelet 287 (WNL) Absolute Neutrophils 15.36 (high) Total Protein 5.5 (low) Albumin 2.6 (low) Calcium 8.5 (WNL) Total Bili 0.5 (WNL) ALK Phos 179 (high) AST/ALT 18/21 (WNL) Glucose 102 (high) BUN 33 (high) Creatinine 1.75 (high) Sodium 135 (low)

Insulin Lispro 12 units subcutaneous BID (rapid-acting) Insulin Glargine 20 units subcutaneous 3 times QD (long-acting) ICY HOT (30% menthol) topical BID **Transplant Related** Bactrim DS 800-160 mg MON-WED-FRI via NG/CORPAK Valganciclovir 450 mg MON-WED-FRI at 6 pm via NG/CORPAK Tacrolimus 2 mg liquid Q 12 H (6am & 6pm) **Other:** Midodrine 15 mg Q 8 H via NG/CORPAK Melatonin 9 mg QD at 8 PM via NG/CORPAK Pantoprazole 40 mg QD at 6 am via NG/CORPAK Sevelamer carbonate 800 mg with meals via NG/CORPAK Simethicone 80 mg chewable PO QID PRN Seroquel 50 mg Q HS via NG/CORPAK Seroquel 25 mg PRN TID via NG/CORPAK Neurontin 100 mg BID via NG/CORPAK Eliquis 5 mg BID via NG/CORPAK Zofran 4 mg IV Q 6 H PRN Colace 100 mg BID via NG/CORPAK Polyethylene Glycol 17 g QD	Potassium 3.7 (WNL) Chloride 93 (low) CO2 30 (WNL) EGFR 43 (low)

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
1. Incontinent of stool and urine resulting in incontinent-associated dermatitis. *Is the patient aware? Make sure this is clear.*	1. Maintain clean dry peri area using incontinent pad or depend, change Q 8 H and PRN soiling with stool or feces. ← *specify when each of these would be indicated. Brief in bed is not ideal.* Apply Desitin to perineum, perianal area and sacrum BID and	1. Skin remains is clean, dry and clean and intact, without redness or breakdown. Incontinent-associated dermatitis resolves. Patient participates in self-care as abilities allow and alerts staff when	1. Wet skin is susceptible to damage from friction and shearing forces, and skin flora can penetrate the disrupted barrier, causing further irritation and inflammation. Moisture-associated skin damage (MASD) can rapidly lead to excoriation and skin breakdown. MASD includes incontinence-

	as needed. Apply ABD pad to sacrum, change daily and PRN. Bathe patient and maintain clean bed environment daily and PRN. Apply pH-balanced moisturizer (3M Cavilon Extra Dry Skin Cream #3386) to skin after bathing, or peri skin cleansing. Maintain Sage Primofit + External Urine Management for the male anatomy, With penis positioned into the device to collect urine. Change QD.	wet. No additional wounds will form. 2. Turning record will be recorded in patient's chart. – *make sure these are not goals.*	associated dermatitis, which is caused by prolonged skin exposure to urine and stool (Voegeli & Hillery, 2021). 2. Repositioning is an integral component of pressure injury prevention and treatment; it has a sound theoretical rational (Gabison, et al., 2022). Specialized support surfaces are an intervention often used to prevent pressure injuries. The use of high-tech support surfaces are an effective measure to prevent pressure injuries (Prado et al., 2021)
2. High Risk for nonhealing of current incontinence-associated dermatitis (IAD) and potential for pressure injury and AID to additional areas. Braden Score: 11 **Sensory perception very limited:** sensory impairment that limits the ability to feel pain/discomfort over half of the body. **Constantly moist**: constantly moist from perspiration, urine, and stool. Dampness detected every time patient is moved or turned. Chairfast: ability to walk is severely limited	2. Maintain every two-hour turning/repositioning to off-load sacrum and ischium. Reinforce the importance of off-loading with patient each shift. Use age-appropriate terms Maintain Stryker Mattress with Isotour blower (low air loss). Encourage patient to reposition self, reinforcing rational. Using	Patient states understanding of off-loading sacrum with wedges, turning, repositioning to assist in wound healing. He assists with repositioning as his condition allows. Stryker Mattress with Isotour blower (low air loss) is in place with no issues. Patient assists in repositioning/off-loading as his condition allows, using upper body strength.	

Mobility is minimal: makes occasional slight changes in body or extremity position but does not make frequent or significant changes independently. **Nutrition is very poor**: rarely eats complete meals, occasionally will take dietary supplements, receives less than the optimum amount of tube feeding. **Friction/shear potential problem:** requires minimum assistance, during a move skin probably slides to some extent against sheets, chair restraints, or other devices, maintains a relatively good position in a chair or bed most of the time but occasionally slides down. *Make sure numerical subscore is present.* 4. High risk for shear or friction skin damage.	age-appropriate explanation. Maintain Tru-Vue heel protectors to prevent heel breakdown. Maintain Medline Comfort Glide Sheet (Oracle # 1113852) and turning wedges (Oracle # 1062865) Maintain seating cushion (Oracle # 1066990) in chair under buttocks when patient is up to a chair. 4. Head of the bed must be maintained at 30 degrees. Not higher to prevent friction/shear.	Tru-Vue heel protectors remain in place while patient is in bed and heels remain intact without redness. 4. Head of bed remains at 30 degress. Patient maintains skin integrity without shear or friction damage. Patient assists in repositioning/off-loading as his condition allows, using upper body strength. 5. Patient maintains current body weight as evidenced by weight Q	The National Pressure Injury Advisory Panel recommends a heel protector to elevate & off-load heels completely and distributes the weight of the leg along the calf without placing pressure on the Achilles tendon (NPIAP, 2024). (Need reference)

5. High risk for altered nutrition and dehydration	5. Regular diet during the day encourage PO 3 meals and 2 snacks. PO increased fluids to 1.5 L 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) Nutrition consult for optimized nutrition.	Mondays. Albumin level is within normal limits. Total protein level is within normal limits. Patient maintains hydration as evidenced by lab values, assessment of oral mucosa, weekly weight 6. Lidocaine patch is applied as ordered.	5. The prevention and treatment of pressure ulcers involves strategies to optimize hydration, circulation, and nutrition. Adequate nutrient intake can reduce the risk factor of malnutrition and promote wound healing in existing pressure ulcers (Langer et al., 2024).
6. High risk for pain secondary to recent liver transplant (healing Mercedes incision), chronic back pain, IAD to sacrum with open areas. *In general, make sure active problems are addressed – there is something in place/happening that is causing this risk – the root cause. Make sure that is addressed. Risks should be moreso explored in the rationale section.*	6. Lidocaine patch – apply to skin of right low back (Alternate on/off Q 8 hours) Tylenol 500 mg liquid via NG/CORPAK PRN Q 4 H Oxycodone 5 to 10 mg liquid via NG/CORPAK PRN Q 4 H Robaxin 500 mg PRN TID via NG/CORPAK *Per order.* Encourage patient to request pain medication as needed.	Patient states his pain is controlled to an acceptable level per 0 – 10 pain scale. . Patient asks for PRN pain medication and participates in therapy and self-care after PRN pain medicine is administered.	Individuals with chronic wounds report pain is the most challenging aspect of living with a chronic wound. Current therapeutic options are insufficient. Patients report pain associated with their chronic wound has the most significant and detrimental impact, and the main area where they wish to see more intervention, invention and research. Individuals who experience pain most, or all of the time with chronic wounds report a clinically significant decreased health-related quality of life compared to chronic wound patients without persistent pain (Healy et al., 2023).

	Consider social consults/d/c prep etc.		

References:

Healy, C. R., Gethin, G., Pandit, A., & Finn, D. P. (2023). Chronic wound-related pain, wound healing and the therapeutic potential of cannabinoids and endocannabinoid system modulation. *Biomedicine & Pharmacotherapy*, 168, 115714. https://doi.org/10.1016/j.biopha.2023.115714

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

Langer, G., Wan, C. S., Fink, A., Schwingshackl, L., & Schoberer, D. (2024). Nutritional interventions for preventing and treating pressure ulcers. The Cochrane Database of Systematic Reviews, 2(2), CD003216. https://doi.org/10.1002/14651858.CD003216.pub3

National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia. https://ehob.com/wp-content/uploads/2024/02/Heel-Protector-Brochure-DIGITAL.pdf

Normandin, S., Safran, T., Winocour, S., Chu, C. K., Vorstenbosch, J., Murphy, A. M., & Davison, P. G. (2021). Negative pressure wound therapy: Mechanism of action and clinical applications. Seminars in Plastic Surgery, 35(3), 164–170. https://doi.org/10.1055/s-0041-1731792

Prado, C. B., Machado, E. A., Mendes, K. D., Silveira, R., & Galvão, C. M. (2021). Support surfaces for intraoperative pressure injury prevention: systematic review with meta-analysis. Latin American Journal of Nursing, 29, e3493. https://doi.org/10.1590/1518-8345.5279.3493

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Voegeli, D., & Hillery, S. (2021). Prevention and management of moisture-associated skin damage. British Journal of Nursing. 30(15), S40–S46. https://doi.org/10.12968/bjon.2021.30.15.S40

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: Using the Braden scale, assess for pressure injury risk. **You must submit your completed Braden risk assessment with your care plan.	5	*4*	*See comments*
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	*11*	*See comments*
	Propose alternative products. Include generic & brand names	4	*0*	*What can be used if the primary product you direct is not available? We must be flexible to create multiple ways to the same goal.*
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	*6*	
Rationale	Explain the rationale for identified interventions	6	*6*	
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1	*1*	
	Proper grammar & punctuation used	1	*1*	
	References: See the course syllabus for specific requirements on references for all assignments	1	*1*	
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50		*44/50*	

Additional comments:

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Hi Patricia – see my notes throughout this complex care plan – you have reached the 80% threshold on this assignment and no further work is needed on it. You remaining continence submissions should be chosen from the virtual case study section (see course references). Reach out with any further questions.
-Mike

Reviewed by: _Mike Klements 10/3/24_received__ Date: _10/4/24