WOC Complex Plan of Care

Name: _Yoselyn Soto_____ **Patient Encounter Date:** _10/3/2024_____

Preceptor for Patient Encounter: _Candace Beeghly_____

Clinical Focus: Wound _x_ Ostomy ____ Continence ____

Number of Clinical Hours Today: _10_

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
Medical history: 57-year-old T4 paraplegic male with chronic suprapubic catheter, previous ostomy, asthma, HTN, PAD s/p previous right AKA, Hx of ischial/sacral osteomyelitis, chronic sacral ulcer, who was recommended by wound care specialist Dr. Conlan to be admitted to the hospital for suspected osteomyelitis of the right ischium as patient was reporting subjective fevers, chills. He was started on empiric Zosyn and vancomycin upon arrival to the hospital. Consultation was placed to general surgeon and ID specialist. General surgeon proceeded with taking patient to the OR on 9/21 for debridement of sacral ulcer. ID specialist recommended continuation of IV vancomycin and Zosyn and to monitor results for Intraoperative cultures. Vancomycin switched to daptomycin per ID. Patient was agreeable to SNF placement as recommended by therapy. He was also evaluated by wound care specialist on 9/23 and advised wound VAC to both ulcers. Care coordinator asked to make arrangements for SNF placement including wound	**Albumin Level** **Date / Value / Ref Range / Status** **09/26/2024 — 3.0 (L) — 3.5 - 5.0 g/dL — Final** **09/20/2024 — 2.5 (L) — 3.5 - 5.0 g/dL — Final** **Date / Value / Ref Range** **09/26/2024 — 95 — 60 - 105 mg/dL** **09/24/2024 — 105 — 60 - 105 mg/dL** **09/23/2024 — 89 — 60 - 105 mg/dL** **Date / Value / Ref Range** **09/26/2024 — 23 — 7 - 26 mg/dL** **09/24/2024 — 10 — 7 - 26 mg/dL**

VAC.
ID specialist advised transitioning to p.o. cefuroxime 500mg BID to complete a 2-week course upon DC.
Medically cleared for DC to SNF. Pending placement at SNF, now pt wants HHC, it was arranged.
Ostomy and suprapubic cath care as indicated
Pt is cleared by all, stable to be discharged to home with HHC.

Surgical Procedure: 9/21/2024 DEBRIDEMENT OF RIGHT ISCHIAL WOUND AND SACRAL WOUND (Right) by: Joseph Abdellatif Ibrahim, MD

Last recorded vitals:
BP 115/59
Heart rate 90
Resp 16
Temp 36.6 C
Sat O2 96%
No pain

09/23/2024	**12**	**7 - 26 mg/dL**

Date	Value	Ref Range
09/26/2024	**0.62 (L)**	**0.70 - 1.30 mg/dL**
09/24/2024	**0.55 (L)**	**0.70 - 1.30 mg/dL**
09/23/2024	**0.67 (L)**	**0.70 - 1.30 mg/dL**

Date	Value	Ref Range
09/24/2024	**7.2**	**4.4 - 10.5 x10(3)/uL**
09/23/2024	**7.4**	**4.4 - 10.5 x10(3)/uL**
09/22/2024	**7.9**	**4.4 - 10.5 x10(3)/uL**

Date	Value	Ref Range
09/24/2024	**9.5 (L)**	**12.6 - 16.7 g/dL**
09/23/2024	**9.7 (L)**	**12.6 - 16.7 g/dL**
09/22/2024	**9.5 (L)**	**12.6 - 16.7 g/dL**

Date	Value	Ref Range
09/20/2024	**1.4**	**ratio**

Date	Value	Ref Range
09/20/2024	**15.7 (H)**	**9.5 - 13.3 second(s)**

Pathology Tissue Exam 9/21/2024

Final Diagnosis

1. **SKIN AND SOFT TISSUE, RIGHT ISCHIAL WOUND, DEBRIDEMENT: - ULCERATED SKIN AND SOFT TISSUE.**

2. **SKIN AND SOFT TISSUE, SACRAL**

WOUND, DEBRIDEMENT:
- ULCERATED SKIN AND SOFT TISSUE.

Aerobic Culture

Date	Value
9/21/2024	Rare Escherichia coli Abnormal Predominant Corynebacterium striatum Abnormal (spine, sacral)
9/21/2024	One colony of Corynebacterium striatum Abnormal (buttock, right)

Anaerobic Culture

Date	Value
9/21/2024	Mixed microbial flora with no predominant organism (spine, sacral)
9/21/2024	No anaerobes isolated (buttock, right)

Wound Culture

Date	Value
09/19/2024	Normal skin flora isolated (swab from buttock, right)

Assessment	Plan/Interventions/	Evaluation	Rationale

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	Alternatives		
-Impaired tissue integrity related to excessive/poor management of pressure redistribution/wheelchair bound **Sacral wound** Measures 9.5 cm x 12 cm x 2.2 cm (LxWxD) undermining at 7 o'clock 1.2 cm. Moist, red wound tissue with minimal slough. Bone is palpated. Large amount of serosanguineous drainage with some thick yellow drainage. No odor, Minimal peri-wound erythema. **Right buttock wound** Measures 6.5 cm x 5 cm x 2.5 cm circumferential undermining 3 cm. Bone palpated. Large serosanguinous with some thick yellow drainage. No odor, peri-wound is intact with minimal erythema. Patient had a surgical debridement for both wounds on 9/21/2024. Wound vac started by WOC nurse 9/23/2024, on 9/27/2024 patient sacral wound was drainage purulent, WOC nurse decided to remove wound vac from sacral area temporary and placed wet to dry dressing with dakins solution twice a day. On 10/3/2024 WOC nurse decided to reinstall wound vac to sacral wound since wound was revealing healthy granular tissue. Wound vac setting increased to	-Patient to remain on Envela bed with Trapeze. -WOC nurse to apply NPWT 2 times a week (Mondays-Thursdays) to sacral and right buttock wound (with bridging technique) with settings at 150 mmHg -Nursing floor to assess pump & dressing to ensure functioning every shift. -If bright blood noted in the tubbing and/or canister turn NPWT off apply pressure and call MD. -Floor Nursing staff to troubleshoot alarms: 1. Check tubing for kinks, may need to replace canister or track pad if blockage persists 2. Keep machine plugged in when not ambulating 3. Change cannister weekly and when as needed 4. If air leak noted. Patch with extra drape tape or tegaderm -NPWT should not be interrupted for >2 hours. -If unable to troubleshoot NPWT and WOC nurse is unavailable (Per local hospital	Patient will not be readmitted to the hospital due to wound complications. The wound will continue to heal, and measures will continue decreasing, without any signs of infection. Patient can expect a prompt recovery of the wound without problems or additional declining.	Wounds treated with NPWT healed at double the rate compared to those treated with sodium hypochlorite gauze dressings (Rappl & Brienza, 2022). NPWT functions by reducing edema to enhance perfusion, eliminating exudate while preserving a moist wound environment, and stimulating intracellular mechanisms that facilitate healing through deformation or stretching (Netsch, 2022). The application of silver diminishes the growth of bacteria and the likelihood of wound infections, improves in the management of active infections, and mitigates the risk of nosocomial wound infections. Silver exhibits antibacterial efficacy at low concentrations, including antibiotic-resistant bacteria such as MRSA and vancomycin-resistant enterococci (VRE). Research on wound healing demonstrated markedly favorable effects with silver

150 mmHg per APRN verbal order.	policy, due to wound features and complexity of the wounds, NPWT must be changed per WOC nurse). -Schedule follow up appointment at outpatient wound clinic for NPWT dressing change upon discharge. -Alternative dressing: Cleanse with Dakins solution and gauze, pat dry, apply skin prep to peri-wound, gently fill wounds with silver dressing, cover with ABD pad and secure with tape, every day or when soiled.		therapy. Silver dressings operate through one of two mechanisms: the silver may be released to the wound bed to eliminate organisms on the wound surface, or the silver may be maintained within the dressing, targeting bacteria present in the exudate absorbed by the carrier dressing Weir & Schultz, 2022).

References:

Rappl, L., & Brienza, D. M. (2022). Skin and wound care for the spinal cord-injured patient. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management (2nd ed., pp. 293-313). Wolters Kluwer.

Netsch, D. (2022). Refractory wounds: Assessment and management. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management (2nd ed., pp. 214-233). Wolters Kluwer.

Weir, D., & Schultz, G. (2022). Assessment and management of wound-related infections. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management (2nd ed., pp. 187-213). 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: _____