WOC Complex Plan of Care

Name: ___Doris Elliott_____ Patient Encounter Date: __10/4/24_____

Preceptor for Patient Encounter: _____Patti Grossnickle_____

Clinical Focus: Wound _x___ Ostomy __x__ 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
History: The patient is a 59-year-old female who presents to the clinic for assessment and care of abdominal wounds. Patient medical history includes diverticulitis, endometriosis, depression, anxiety, arthritis, and Hashimoto's disease. She was diagnosed with pyoderma gangrenosum during recent hospitalization for wounds. Patient presented to the ER on 08/24/24 status post-surgical intervention at another facility where she underwent a sigmoid resection that was complicated by an anastomotic leak and was brought back to the OR for a diverting colostomy. The patient developed an extensive wound to the peri-stomal area in the left lower quadrant and multiple areas to the right side of the abdomen where laparoscopic incisions were made. A wound VAC was previously placed to the peri-stomal wound and the patient was taken to the operating room for each dressing change to be done under anesthesia due to the pain associated with the care. The decision was made during the most recent hospitalization to discontinue the wound VAC and utilize hydrofera blue classic to the left lower quadrant wound. The wounds to the right side of the abdomen were dressed with 50/50 mupirocin/clobetasol. The patient was seen in office after discharge from the hospital on 09/06/24 and referred to University of Miami Hospital after the patient reported no output was noted from the colostomy for a week, there a colonoscopy and	**Vital signs:** BP: 133/83 HR: 68 Temp: 36.3 C (97.3 F) Resp: 18 O2: 98% Labs: WBC: 5.4 RBC: 3.53 Hemoglobin: 9.6 Hematocrit: 31.3 Sodium: 135 Potassium: 4.2 Chloride: 98 Protein, total: 6.3

biopsy were performed, results are pending. Ostomy output has resumed. The patient presents today for continuation of dressing changes and care. **Current medications:** Gabapentin 300 mg PO 3x daily Hydromorphone 2 mg tab PO every 6h as needed for pain Polyethelyne glycol 17g/dose powder PO once daily Diclofecac XR 100 mg tab PO every day PRN for inflammation Levothyroxine125 mcg tab PO daily Trazodone 125 mcg tab PO at bedtime as needed Clonazepam 2 mg tab PO twice daily as needed Duloxetine 60 mg cap PO every 12 hours **Allergies:** No known allergies **Assessment and interventions:** Left lower quadrant abdominal wound 4.4x11.4x2.5 with stoma in central portion of wound. Majority of wound bed with granular tissue and minimal slough present, moderate amount of serosanguinous drainage. No odor noted. Peri-wound is pink and fragile. Wound cleansed with vashe soak and lidocaine 4% applied to the wound bed. Wound lightly packed in deepest portion with systagenix promogran that was pre-moistened with normal saline. Hydrofera clue classic activated using normal saline and applied to the wound bed around the stoma. Convatec duoderm extra thin cut to cover hydrofera blue while leaving stoma exposed. Hollister adapt skin barrier paste then applied to duoderm and peristomal area along with coloplast brava barrier ring. Ostomy appliance applied. Right lower abdominal wound 3.2x8.4x0.2. Wound bed red and pink with minimal amount of slough noted. Peri-wound is intact. Moderate amount of serosanguinous drainage. No odor noted. Wound cleansed with vashe soak and lidocaine 4% applied to wound bed. Hydrofera blue ready cut to size of wound and applied to wound base. Wound covered with Convatec duoderm extra thin. Further secured with alleyvn foam dressing. Right medial upper abdominal wound 0.5x4x0.1. Wound bed red and pink, peri-wound skin is	Albumin: 3.2 Glucose: 94

intact. Minimal amount of serosanguinous drainage. No odor noted. Cleansed with vashe soak. Hydrofera blue ready cut to size of wound and applied to wound base. Wound covered with Convatec duoderm exra thin. Further secured with alleyvn foam dressing. **Recommendations:** Continue with dressing changes in-clinic on Mon/Wed/Fri Follow-up assessment with provider weekly Avoid water to wounds Increase protein intake Continue to monitor for fevers, increase in pain/tenderness and/or redness/swelling, purulent drainage/odor Change ostomy appliance only as needed for leakage between dressing changes to avoid wound contamination	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Full thickness wounds of the abdomen. Complicated by diagnosis of pyoderma gangrenosum. Wounds present with granulation to the wound bed with slough present, deepest at 2.5 cm.	Cleanse abdominal wounds with vashe soaked gauze, pat dry. Pack deepest portion of the left lower quadrant abdominal wound with systagenix promogran. Cover with hydrofera blue classic to the wound bed. Cover with duoderm extra thin. Right sided abdominal wounds should be dressed with hydrofera blue ready and duoderm extra thin after cleansing. Ensure ostomy appliance is	Dressing changes intact at time of next dressing change scheduled each mon/wed/fri. Increased granulation tissue and decrease slough present in wound bed. Measurements of wound decreasing at acceptable rate until healed. Patient will report no leakage from the ostomy appliance or compliance with changing appliance immediately if leakage is noted.	The local wound care therapy should manage exudate and maintain a moist wound environment, and foams are often suggested (Pieper, 2022). In granulating wounds collagen and other protease-lowering dressings will lessen MMPs and decrease healing time (Croitoru et al., 2020). Methylene blue and gentian violet foams both absorb and contain exudate and provides anti-

	checked frequently for leaking to ensure no contamination into wounds. Educate patient about the signs and symptoms of infection. Promote increased protein intake.	Patient will express understanding of signs and symptoms of an infection and report to the provider if any symptoms develop. Patient will report increased protein intake with each meal.	microbial properties (Weir & Schultz, 2022). Surgical debridement of wound should be avoided if possible and dressings that promote autolytic debridement, such as duoderm, are more gentle and favorable (Croitoru et al., 2020). In patients with Pyodema Gangrenosum (PG) lesions of the peri-stomal skin plane the WOC nurse should take extra consideration in appliance selection to avoid leakage (Pieper, 2022). Length, width, and depth of the wound should be measured with each assessment to facilitate accurate longitudinal monitoring (Croitoru et al., 2020). In patients with pyoderma gangrenosum pain is not an accurate indication of infection so should be assessed for spreading erythema, malodor, or lymphangitis (Croitoru et al., 2020).
Moderate pain and anxiety associated with dressing changes	Lidocaine 4% to be used during dressing changes for topical analgesic.	Patient will express manageable pain levels during dressing changes.	Intralesional lidocaine has been proven to be highly effective in pain management in patients with

Patient expresses need for breaks frequently during removal and application of dressings. Patient observed with increased respiratory rate and grimacing. Patient with eyes closed during entire dressing change.	Facilitate gentle removal of the hydrofera blue from the wound bed by using normal saline to loosen the dressing. Use Hollister adapt medical adhesive remover spray or brava coloplast adhesive remover-sting free. Encourage patient to optimize timing of PO pain medication prior to dressing changes. Allow extra time in appointment. Provide reassurance and encouragement to patient through out dressing change process.	Patient will not experience trauma to the wound bed during dressing removal. Patient will not express pain or burning cause by adhesive remover product. Patient will express that PO pain medication was taken one hour prior to appointment. Patient will not feel rushed and will be comfortable asking for a break if needed. Patient will be express manageable levels of anxiety regarding dressing changes and frequent appointment	pyoderma gangrenosum (Croitoru et al., 2020). Dressings removal should be easy to prevent trauma to the wound and minimize pain (Croitoru et al., 2020). Adhesive removers are used to prevent skin stripping and patient discomfort. Adhesive removers containing alcohol should be avoided as a stinging sensation to an open wound will occur (Lund & Singh, 2022) Analgesics are an important factor in managing the patient's comfort level and helping to facilitate compliance with frequent dressing changes (Croitoru et al., 2020). Analgesics will help with anxiolytic qualities and improved quality of life during the wound care process (Croitoru et al., 2020).
Braden score: 19 Sensory perception: 4- no Impairment, increased sensation of pain Moisture: 4- rarely moist, fecal	Encourage patient to manage pain levels as needed and prescribed. Encourage frequent checking of the ostomy appliance and emptying at 1/3 full or sooner. Change the ostomy appliance only	Patient will express adequate pain level management that will help patient to have appropriate sensory perception. Patient will state that frequent emptying has occurred and no	Patients with increased pain levels often express desire not to move once comfortable, adequate pain management may promote movement (Borchert, 2022). Utilizing proper mobilization

matter contained within ostomy appliance and patient continent of urine. Activity: 4- walks frequently. Patient independent with walking and lives at home with husband Mobility: 3- slightly limited. Patient uses walker but is independent Nutrition: 2- probably inadequate. States her appetite is low but does eat small 2-3 small meals per day. Protein and albumin levels low. Friction/shear: 2- potential Problem. Moves independently but feebly, sliding observed during position changes.	if leakage is noted. Speak with physician regarding possible physical therapy referral. Place referral to nutritionist regarding diet to promote wound healing. Provide assistance with position changes and encourage patient to refrain from "scooting" if possible.	leakage noted between dressing changes. Patient will have scheduled appointment to begin physical therapy. Patient will have scheduled appointment to speak with nutritionist. Patient will express understanding regarding proper body mechanics and why "scooting" can cause skin breakdown.	techniques will help to prevent friction and shear (Borchert, 2022) and these patients should be extra careful to avoid any minor trauma to the skin. A low nutritional score on the Braden scale should prompt supportive interventions (Emmons & Dale, 2022). Promoting adequate nutrition will aid in both wound healing and pressure injury prevention (Emmons & Dale, 2022).

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.396-424). Wolters Kluwer

Croitoru, D., Naderi-Azad, S., Sachdeva, M., Piguet, V., & Alavi, A. (2020). A wound care specialist's approach to pyoderma gangrenosum. *Advances in Wound Care*, *9*(12), 686–694. https://doi.org/10.1089/wound.2020.1168

Emmons, K.R., & Dale, B.A. (2022). Palliative wound care. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp.776-792). Wolters Kluwer

Lund, C., & Singh, C. (2022). Skin and wound care for neonatal and pediatric populations. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp.234-256). Wolters Kluwer

Pieper, B.A. (2022). Atypical lower extremity wounds. In L. L. McNichol, C. R. Ratliff & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 585-602). 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: _____