WOC Complex Plan of Care

Name: _____Patricia Weimer_____ **Patient Encounter Date:** ___9/24/2024_____

Preceptor for Patient Encounter: _____Aaron Fischer_____

Clinical Focus: Wound ____ Ostomy __X__ Continence ____

Number of Clinical Hours Today: _8___ (Note: this day was documented in a separate journal entry) ← *I have counted this assignment as your journal for this day (9/24).*
At the time of submission you have one extra journal submitted for ostomy- marking journal from 9/26. This will be sufficient to cover your ostomy hours.

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
48-year-old female with a past medical history of paraplegia (2011, T1 - T6 damage – infarction during hypotensive episode), diverting colostomy, sigmoid conduit urinary diversion (2022), Atrial fibrillation, history of DVTs, chronic kidney disease, adrenal insufficiency (steroid related), Chronic sacral osteomyelitis, multiple sacral and ischial pressure wounds status post debridement, left above the knee amputation (gangrene 2024), frequent infections/septic episodes. Congestive heart failure, vascular disease. Former smoker (stopped 2/23/2013). Type II diabetes. Admitted 9/17/2024 to the Medical ICU for sepsis, hypotension (69/41) secondary to active bleeding pressure injuries, and generalized weakness. ✔ **Medications** Vitamin D-3 5000 units PO QD Cortef 5 mg tablets, 3 tablets (15 mg) PO in the morning, and 1 tablet (5 mg) at night	WBC 8.2 HGB 5.0 HCT 16.7 PLTS 401 Absolute Neutrophils 5.28 APTT 45.6 INR 1.3 Glucose 126 Sodium 134 Potassium 3.4 Chloride 109 CO2 13 BUN 15

Sodium Bicarbonate 650 mg, 2 tablets PO TID Midodrine 10 mg, one tablet PO 3 TID Multivitamin one capsule PO QD Zinc Sulfate 220 mg (50 mg zinc) PO QD Extra Strength Tylenol 500 mg – 2 tabs PO Q 6 H PRN pain. Protonix 40 mg PO QD at 6 am Paxil 10 mg PO QOD Synthroid 200 mcg one tab PO QD Ventolin HFA 90 mcg 2 puffs Q 4 H as needed for wheezing/shortness of breath. Lactose-free meal supplement PO 3 times QD with each meal. Tylenol 1000 mg PO Q 6 H as needed for pain Oxycodone 2.5 mg PO Q 8 H as needed for pain Insulin – regular human (short-acting) subcutaneous injection with meals and HS per sliding scale. Solu-Cortef 50 mg IV Q 6 H Heparin subcutaneous injection 5000 units Q 12 H	Creatinine 1.10 Albumin 1.4 Total Protein 5.6 Calcium 7.5 ALK Phos 167 ALT/AST 8/13 Total Bili <0.2 CRP 12.7 O2 100% on Room Air Lungs clear to auscultation MRSA negative COVID/RSV/Flu negative

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
1. Colon conduit stoma present in right lower quadrant. Stoma budded – but urine functioning at the skin level at 8 o'clock, edematous, pale pink (HGB 5.5), MCJ intact. Peristomal skin intact contour is rounded with semisoft supportive tissue. Urine is yellow with large amount of mucous. *Part of this holistic assessment should be the patient's current ostomy systems and success.*	1. Record urine volume, quality, and color Q 8 hours. Contact physician if no output for 6 to 8 hours, if color changes to dark amber, if mucous content increases. ✔ Assess colon conduit stoma every 4 hours for change in appearance. Notify physician immediately if stoma color turns dark, purple or black and document each assessment details. Change Colon Conduit Pouch	1. Stoma and peristomal skin remain intact, and stoma remains pink to red in color. Dressing is changed every three days. Wear time is 3 days without leaking.	1. Healthcare providers should have basic skills and updated knowledge on the management and complications of stomas, to act as the first crisis manager for ostomates. Multidisciplinary team follow-up is crucial for optimizing the QoL of ostomates, with coordination of care and information sharing across all team members (Tsujinaka, 2020). ✔ As convex pouching systems are

	before Colostomy Pouch change. Change pouch every 3 days. -Remove old pouch using adhesive remover. Hollister Adapt Universal Adhesive Remover Wipes. Alternative: Brava Coloplast Adhesive Remover - Sting Free Remover -Cleanse skin with Vashe solution. If Vashe solution not available stoma and peristomal skin can be cleansed with warm water. -Apply Convatec Stomaheasive powder lightly to peristomal area and dust off access. Coloplast Brava powder could be used as an alternative. -Apply Cavilon No Sting Liquid Skin Barrier over peristomal skin and allow to dry. Marathon skin protectant MSC093005 could be used as an alternative. -Apply Coloplast Sensura Mio 1	2. Stoma and peristomal skin remain intact, and stoma remains pink to red in color.	used to provide a secure seal for the appropriate clinical presentation, guidance on the use of convexity would benefit clinicians. Convexity assists in flattening the skin surrounding the stoma and directing the flow from the os into the pouch resulting in decreased leakage, which has been associated with a decrease in peristomal skin complications (Stoia-Davis et al., 2022). -Opaque pouches feature peek-a-boo-inspection window. Affords easy frequent inspection of stoma. (Coloplast, 2024) The principles of pouch selection are based on the following: -Consistent wear time, is the ability to maintain a seal for a predictable period of time without leaking between application and removal. -Intact peristomal skin when the pouch is removed (Colwell & Hudson, 2022).

	piece, convex light cut to 40 mm. -Secure pouch with Mefix tape picture framed over flange. Alternative: Hollister Urostomy 1 PC pouch system (Beige # 8439111) convex Will fit up to 51 mm stoma -Write date and time on flange, and document this in the patient's record. -Connect pouch to gravity drainage bag.	Dressing is changed every three days. Wear time is 3 days without leaking.	
2. End colostomy stoma present in lower left quadrant. Stoma budded, pale pink (HGB 5.5) with MCJ intact. Effluent dark brown liquid. Peristomal skin intact. ✔	2. Monitor output, record effluent volume, quality, and color Q 8 H. Contact physician if no output for 6 to 8 hours. Assess end colostomy stoma every 4 hours for change in appearance. Notify physician immediately if stoma color turns dark, purple or black and document each assessment details. Change End Colostomy Pouch after Colon Conduit Urostomy. Change pouch every 3 days.		2. Periodic review of the fit of the pouching system, wear time, and utilization should be done keeping in mind the person's abdomen changes (loss or weight gain, abdominal surgery, changing contours due to aging) the stoma and the surrounding area can change and an alteration in the pouching system may need to be considered (Colwell & Hudson, 2022). Skin barrier powder is a hydrocolloid that can be used to absorb moisture and prevent skin denudation (Colwell & Hudson, 2022).

	-Remove old pouch using adhesive remover. Hollister Adapt Universal Adhesive Remover Wipes. Alternative: Brava Coloplast Adhesive Remover - Sting Free Remover -Cleanse skin with Vashe solution. If Vashe solution not available stoma and peristomal skin can be cleansed with warm water. - Apply Convatec Stomaheasive powder lightly to peristomal area and dust off access. Coloplast Brava powder could be used as an alternative. -Apply Cavilon No Sting Liquid Skin Barrier over peristomal skin and allow to dry. Marathon skin protectant MSC093005 could be used as an alternative -Apply Coloplast Brava Protective Ring # 12035 around stoma.		Skin barrier spray creates a dry pouching surface to allow for good adhesion (Colwell & Hudson, 2022). A skin barrier ring is an adhesive hydrocolloid washer that can be used around the stoma to enhance the seal by providing an additional solid skin barrier and /or to level out the area around the stoma. Elastic barrier strips are used to secure the outer seal of the pouching system. (Colwell & Hudson, 2022).

	Hollister Adapt Skin Barrier Ring with ceramide #8805 could be used as an alternative -Apply Coloplast Sensura Mio 1 piece, convex light cut to 51 mm. Alternative Pouching System: Hollister Drainable 1 pc pouch #89511, Cut to fit Soft Convex with Ceramide. Will fit up to 55 mm stoma. -Secure pouch with elastic barrier strips – Coloplast Brava #120721 Medipore H 3M Tape # 2862 can be used as an alternative -Write date and time on flange, and document this in the patient's record.		
3. Anemia and Hypotension - High risk for decreased blood flow to stomas related to severe anemia and hypotension. Potential for stoma necrosis.	3. Monitor HGB and blood pressure. Notify physician when lab results indicate anemia. (HGB < 7). Vital signs: Notify physician if blood pressure cannot be maintained at systolic BP > 90 mmHg, or	3. Hemoglobin remains above 7 and blood pressure above 90/60 mmHg	3. Clinically the stoma may have become discolored and patients may complain of a sore stoma site. Although stoma necrosis is a rare complication, this condition is an emergency and requires urgent consultations with surgical

	Diastolic > 60 mmHg	Stoma retains pink to red color exhibiting adequate perfusion.	services. While minor stoma discolorations may be carefully watched in the early postoperative period without the requirement of surgical intervention, severe necrosis requires timely revision of the stoma (Babakhanlou et al., 2022).
4. Nutritional deficit as evidenced by albumin 1.4 / total protein 5.6	4. Consult nutritional services. Daily weight.	4. Albumin and Total Protein trend toward normal limits. Maintains or gains weight.	4. Albumin is among the most important proteins and plays a significant role in maintenance of colloid osmotic pressure, wound healing, decreasing oxidative damage, carrying drugs and endogenous substances, and coagulation. Hypoalbuminemia is common in acute and chronic illnesses (Mazzaferro, & Edwards, 2020). Malnourished patients with protein deficiency have a high risk of infection, impaired wound healing, and prolonged hospitalization. Hypoalbuminemia is a condition associated with a deficiency in albumin caused by a reduction in protein intake, and its prevalence is related to patient age and gender, comorbidities, and dietary intake (Utariani et al., 2020).

			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).
5. Unstageable pressure injury wound to sacrum with high risk for additional skin breakdown. Purulent drainage and bleeding on sacral wounds (unstageable) – acute chronic sacral pressure wounds with visible sacral bone. BRADEN SCORE 8 **Sensory perception** - Very limited: sensory impairment limits the ability to feel pain/discomfort over half of the body. **Moisture** - Constantly moist: moist almost constantly by perspiration, urine, etc; dampness is detected every time the patient is moved or turned. **Activity** - The patient is confined to bed. **Mobility** - Very limited: makes	5. Maintain every two-hour turning/repositioning to off-load sacrum and ischium. Reinforce the importance of off-loading with patient or caregiver each shift. Maintain Stryker Mattress with Isotour blower (low air loss). Encourage patient to reposition self, reinforcing rational, as patient abilities allow. Maintain Tru-Vue heel protectors to prevent heel breakdown. Sacral Dressing Change:	5. Turning record will be recorded in patient's chart. Patient or caregiver states understanding of off-loading sacrum with wedges, turning, repositioning to assist in wound healing. 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. Tru-Vue heel protector remains in place while patient is in bed and heel remains intact without redness.	5. 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) The National Pressure Injury Advisory Panel recommends a heel protector to elevate & off-load heels completely and distributes the weight of the leg (Edsberg et al., 2022)

occasional slight changes in body or extremity position but is unable to make frequent or significant changes independently. **Nutrition** - Very poor: evidenced by albumin 1.4 / total protein 5.6 **Friction/shear** – Problem: maximum assistance in moving; complete lifting without sliding against sheets is impossible; frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance High Risk for nonhealing of current wound and pressure injury to additional areas. ✔	-Remove old dressing. -Cleanse wound and periwound area with Vashe solution. -Measure wound and record. -Pat dry gently -Cut Urgotol contact dressing to fit wound bed and place. -Spiral cut Hydrofera Blue and hydrate with sterile saline or sterile water. Squeeze out excess fluid. -Lightly pack Hydrofera Blue into wound bed. Trim as needed. -Cover with an absorbent abdominal pad and secure with Mefix tape. -Change dressing every three days.	(remaining leg, right). Wound measurements decrease in size and granulated tissue increases.	
6. Pain related to multiple comorbidities. Specifically recent amputation, and pressure injury to sacrum.	6. Educate patient about as needed medications available and to ask for pain medications when she experiences pain. Medicate per orders.	6. Patient states understanding of pain regimen and reports pain is well controlled.	6. Pain associated with wound ulcers can be managed with analgesics and other pain management strategies. Effective pain management is essential to improve the patient's quality of life (Koumaki et al., 2023).
7. High risk for decreased mobility and ability to perform activities of daily living.	7. Consult physical therapy and occupational therapy for mobility and ADLs *ok*	7. Patient maintains and increases mobility as well as her ability to perform ADLs.	7. Physical therapy and occupational therapy (PT/OT) are an integral part of the interdisciplinary team on the general medicine service line. PTs

			and OTs are very important members of the interdisciplinary team. PTs and OTs in the acute care setting require high-level thinking to draw conclusions by analyzing and synthesizing findings related to patients' activity and participation restrictions, needs and wants, life context, and ability to participate in therapy (Bednarczyk et al., 2020).

References:

Babakhanlou, R., Larkin, K., Hita, A. G., Stroh, J., & Yeung, S. C. (2022). Stoma-related complications and emergencies. International Journal of Emergency Medicine, 15(1), 17. https://doi.org/10.1186/s12245-022-00421-9

Bednarczyk, M., Pritchard, K., Barquin, W., Beyer, A., & Stankiewicz, C. (2020). Improvement of physical and occupational therapy referral process to reduce unskilled consults. *Journal of Acute Care Physical Therapy* 11(2) https://doi.org/10.1097/JAT.0000000000000115

Colwell, J., Hudson, K., (2022). Selection of pouching system. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.) Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management (2nd ed., pp. 172-188.) Wolters Kluwer. (12)

Edsberg, L. E., Cox, J., Koloms, K., & VanGilder-Freese, C. A. (2022). Implementation of pressure injury prevention strategies in

acute care: Results from the 2018-2019 international pressure injury prevalence survey. Journal of Wound, Ostomy, and Continence Nursing, 49(3), 211–219. https://doi.org/10.1097/WON.0000000000000878

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

Koumaki, D., Kostakis, G., Boumpoucheropoulos, S., Ioannou, P., & Katoulis, A. C. (2023). A narrative review of management of wounds in palliative care setting. *Annals of Palliative Medicine*, 12(5), 1089–1105. https://doi.org/10.21037/apm-23-138

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

Mazzaferro, E. M., & Edwards, T. (2020). Update on albumin therapy in critical illness. *Veterinary clinics of North America. small animal practice*, 50(6), 1289–1305. https://doi.org/10.1016/j.cvsm.2020.07.005

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

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

Stoia-Davis, J., Colwell, J. C., Emodi, K., Fellows, J., Mahoney, M., McDade, B., Porten, S. P., Raskin, E. R., Norman, H. S., Kelly, M. T., & Sims, T. (2022). Survey results on use of a convex pouching system in the postoperative period. Journal of Wound, Ostomy, and Continence Nursing. 49(3), 247–250. https://doi.org/10.1097/WON.0000000000000877

Tsujinaka, S., Tan, K. Y., Miyakura, Y., Fukano, R., Oshima, M., Konishi, F., & Rikiyama, T. (2020). Current management of intestinal stomas and their complications. *Journal of The Anus, Rectum and Colon*, 4(1), 25–33. https://doi.org/10.23922/jarc.2019-032

Utariani, A., Rahardjo, E., & Perdanakusuma, D. S. (2020). Effects of albumin infusion on serum Levels of albumin, proinflammatory cytokines (TNF-α, IL-1, and IL-6), CRP, and MMP-8; tissue expression of EGRF, ERK1, ERK2, TGF-β, Collagen, and MMP-8; and wound healing in sprague dawley rats. *International Journal of Inflammation*, 2020, 3254017. https://doi.org/10.1155/2020/3254017

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	*5*	*See comments- what is the patient currently doing – this is important.*
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	6	*3*	*This needs elaborated upon in the note. What was in place prior to your encounter?*
	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	*N/a for ostomy journal.*	
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 my comments*
	Propose alternative products. Include generic & brand names	4	*0*	*This is not noted*
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	*6*	
Rationale	Explain the rationale for identified interventions	6	*5*	*See my comments*
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		34/45 -1 resub	

Additional comments:

~~*Hi Patricia – see comments throughout this submission. I have counted this assignment as your journal for this day (9/24). At the time of submission you have one extra journal submitted for ostomy- marking journal from 9/26. This will be sufficient to cover your ostomy hours. Some revision/elaboration is needed on this complex care plan. Make sure to*~~

WOC Complex Plan of Care

~~*focus on the details of the ostomy care and interventions. Provide evidence based rationale for your choices and actions. Updates can be done right in this document and have no specific due date – reach out with any further questions! – Mike*~~

See the attached rubric on this assignment. Your revisions are noted and show improvement, but there is still some information missing from this assignment, which is keeping your scoring low. Focus on the ostomy needs for this patient. Make sure to identify alternatives for each product instructed to use in your plan of care. As WOC specialists, we must apply what we know to best help patients find solutions to their current needs. When building your assessment/h+p, make sure you note what the patient was using for interventions prior to your encounter. Your assessment will dictate your directive. I'm confident you can make these corrections. Reach out with any further questions -Mike 10/15/2024

Reviewed by: Mike Klements received 10/7/24 Date: 10/8/2024