WOC Complex Plan of Care

Name: Amy Harlan **Patient Encounter Date:** 10/18/24

Preceptor for Patient Encounter: Bobbi Jo Killing

Clinical Focus: Wound ____ Ostomy ____ Continence __X__

Number of Clinical Hours Today: 8.5

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
72-year-old Male s/p laparoscopic descending loop colostomy, TAP block, flexible sigmoidoscopy, polypectomy, flexible cystoscopy and open cystotomy with placement of suprapubic catheter, being seen POD#3 for rod removal, lesson #1 with patient and son, and leaking suprapubic catheter. **PMH:** HTN, HLD, GERD, systolic murmur, functional urinary incontinence, inflammatory dermatosis, Malignant neoplasm of prostate, persistent testicular pain. **PSH:** Cystoscopy and cold knife incision of fibrotic membranous urethral stricture/ urethral dilation x2, Cystolitholapaxy, robotic radical prostatectomy with lymph node dissection, hernia repair, hand tendon repair, shoulder surgery. **Home Medications:** Apixaban, Metoprolol Tartrate, Amlodipine. **Allergy:** Nitrofurantoin	**Cystoscopy:** Normal anterior urethra until 12F posterior stricture with small stone poking out from lumen. 10F cystoscope used to navigate past stone. Dilated cavity entered with multiple small stones. Visibility d/t stones, small scope, cloudy urine. Suspected location of fistula. **CTA ABD/PEL:** No acute aortic pathology. Ecstatic thorabdominal aorta measuring up to 4.5cm at aortic root**.** **Colonoscopy:** 4 sessile polyps in ascending colon 6-8mm in size. 3 sessile polyps in hepatic flexure 6-8mm in size. 2 semi-pedunculated polyps in rectosigmoid and

Patient walking in hallway when 1st arrived to room. Patient instructed on visit plan and agreeable. Suprapubic catheter in place, little urine in collection bag and leaking around catheter insertion site. Descending loop colostomy to LUQ with Coloplast SenSura 1-piece drainable flat pouch in place and has worn for 2 days. Multiple surgical stab sites with steri-strips intact and covered with Band-Aids. Educated on leaving steri-strips in place until they fall off or become very loose. Educated on signs of infection and wound monitoring. Flushed urinary catheter with 60mL of sterile water. Small blood clot came through catheter tubing. Is now draining clear yellow urine. Reports improvement in abdominal pain afterwards. Education provided on catheter care and flushing. Rod removed with no difficulties per CORS Order on POD#3. Once rod was removed, patient had a lot of effluent coming out of OS, making it difficult to do appliance application. Educated on how rod was holding stoma firm but now that it has been removed, stoma moves more freely and is able to clear out stool that it could not before. Cleansed peristomal skin with water and dried thoroughly. Applied stomahesive powder, Hollister adapt cera ring, Hollister 2 ¼" flange and drainable pouch. Wife was unable to be here today but son is present. Both patient and son highly motivated to learn pouch change procedure and very interactive during today's session. Plan is for Son to do hands-on ostomy care prior to discharge. Patient is from England and primary language is not English. Patient able to understand most of English and son interpreted what he could not understand. Plan is for patient to be potentially discharged tomorrow. DC prep order form, nutrition, ORS, and ostomy change instructions are all ready for tomorrow. Next visit on 10/19/24 for hands-on lesson with son and to finalize DC. Will be having homecare once he is discharged. Reports that prior to surgery, he was having urine present in stool and some fecaluria. Chronic urinary incontinence and occasional fecal incontinence and urgency. Having intermittent abdominal pain. Recently hospitalized 8/19/24 for urinary retention/ UTI. Had urethral stricture and rectourethral fistula.	descending colon 10mm in size. A 10mm semi-pedunculated polyp in transverse colon. Mild diverticula in sigmoid and descending colon. Non-bleeding external and internal hemorrhoids. Area of granular mucosa in distal rectum. Terminal ileum normal. **Na:** 139 **K:** 4.0 **Cl:** 104 **CO2**: 25 **BUN:** 10 **Creatinine:** 0.83 **Glucose:** 109 **Ca: 9.0 Mg: 2.0 Phosphorous: 3.2** **Anion gap:** 10 **eGFR:** 93 **CRP:** 5.4 **WBC**: 5.92 **RBC**: 4.47 **HgB**: 12.7 **Hct:** 38.4 **Plt**: 115 **MCV:** 85.9 **MCH:** 28.4 **MCHC:** 33.1 **MPV:** 10.5 **RDW-CV:** 14.0 **DTYPE:** Auto **Neu%:** 57.1 **ANC:** 3.38 **LYMPH%:** 28.0 **Abs Lymph:** 1.66 **Mono%:** 11.7 **Abs Mono:** 0.69 **Eosin%:** 2.4 **Abs Eosin:** 0.14 **Baso%:** 0.3 **Abs Baso:** <0.03 **Immature Gran%:** 0.5 **Immature Grans ABS:** 0.03 **NRBC:** 0.0 **ABS NRBC:** <0.01 **GLU Point of care:** 148 **Ht**: 190.5cm **Wt:** 102.1kg **SpO2**: 99% **BMI:** 28.12kg/m2 **BP:** 170/74 **Pulse:** 69 **Temp**: 98.5 F

Assessment	Plan/Interventions/ Alternatives	Evaluation	Rationale
Suprapubic catheter not draining:	• Check urinary catheter	• Catheter bag ½	People who require

• Very little urine in drainage bag. • Reports feeling of fullness in bladder. • Abdominal pressure increasing. **Colostomy Gas/ abd bloating/belching**: • Patient reports of having to let a lot of air out of his colostomy pouch. • Reports of feeling more bloated. • Reports increased issues with belching after eating.	bag every hour to ensure it is draining. • Ensure bag is below level of abdomen and free of kinks. • Irrigate urinary catheter with 60mL of normal saline PRN for little to no urine flow with McKesson irrigation tray with piston syringe. *Alternative; Cardinal Health KenGuard Piston Irrigation tray.* • Encourage patient to increase fluid intake. • Monitor for any signs of infection: pain at catheter site, flank pain, cloudy/ foul smelling urine, blood in urine or dark colored. • Bedside nurse to check colostomy pouch during hourly rounding to ensure pouch is not full of air and not attached to flange lock. • Educate patient on	full of clear colored urine. • Bag is hanging off of bed frame. • Per EMR, patients' fluid intake has increased to 2.5L per day. • Per nurse documentation of patient not having any signs of infection. • No record of need for catheter irrigation, do see irrigation kits at patient's bedside and bottle of sterile water. • Colostomy pouch is flat and free of air. • Colostomy pouch is firmly attached to flange of wafer barrier. • Per EMR, patient is no longer drinking coffee or	urinary catheters, collect mucus, stone crystals, or bacteria in their bladder. Irrigation disrupts the debris and mucus, moving it away from the bladder walls. Once floating, the debris will leave bladder through the catheter, to prevent UTIs or formation of bladder stones, (Gillette Childrens, 2024). The best way to reduce gassiness is to avoid foods that cause problems. These foods include Beans, lentils, asparagus, broccoli, cabbage, Brussel sprouts, onions, pears, wheat, artichokes,

Colostomy pouch not staying on/ leaking/ bad odor: • Patient reports problems with pouch staying attached to skin/ skin barrier wafer having loose edges. • Pouch leaks off and on. • Stool has a bad smell.	limiting foods that have potential to increase gas. • Educate patient on limiting foods that can cause increase build-up of air. • Bedside nurse to check colostomy pouch at hourly rounding for any loose wafer edges and secure with tape PRN. • Bedside nurse to check colostomy pouch for any leaks at hourly rounds. Call ostomy team when any leaks are noticed. • If leaks after hours, please change pouching system. Do not secure with tape as stool will breakdown skin due to acidity from gastric contents. Cleanse peristomal skin with water and dry well with gauze. Apply thin layer of Adapt stoma powder	soda. • Per EMR, patient is no longer eating spicy foods, green leafy vegetables, or salad. • Colostomy pouch attached well with no loose edges or tape added. • Per EMR nurse notes, colostomy pouch is being checked with hourly rounding. • Per ostomy nurse note, she came to change ostomy appliance due to start of leak. • Colostomy pouches, skin barrier wafer, stoma powder, barrier rings are at patient's	fruits, oat bran, peas, corn, pasta, and potatoes. When we swallow too much air, it causes abdominal bloating, gas, or belching. These include chewing gum, drinking carbonated beverages, smoking, or eating too fast, (WedMD, 2024). Pouch deodorants come in both liquid and gel form. Put your preferred pouch deodorant in ostomy pouch every time you change or empty your pouch, before reattaching the

Braden Scale: Total score = 19, no apparent risk • Sensory Perception: 3 slight limited due to TAP block. • Moisture: 4 rarely moist, patient now has stool diversion and urinary catheter. • Activity: 3 walks occasionally, spends most time in bed, takes walks with encouragement, little self-motivation. • Mobility: 4 no limitations, able to turn/ reposition self independently, able to sit/lie down on own. • Nutrition: 3 adequate, appetite is slowly returning, eating smaller portions. • Friction/ shear: 2 potential problems, shoots self forward, does not normally pick up body to move forward.	for any skin irritations and brush off excess. Apply Hollister Adapt Cera Ring on peristomal skin directly around stoma. Apply Hollister New Image 2-piece 12" drainable ostomy pouch, transparent pouch 2 ¼" flange. *Alternatives: Safe n' Simple skin barrier ring conforming seal, Safe n' Simple stoma skin barrier powder, ConvaTec Sur-fit Natura 2- piece drainable pouch 57mm* • Bedside nurse to encourage patient to use Adapt Lubricating deodorant to help with odor. *Alternative: Safe n' simple ostomy pouch deodorant.* • Encouraged patient to walk every4x/day. • Teach patient to pick	bedside. • Opened bottle of liquid deodorizer at patient's bedside and deodorizer room spray.	system. The deodorant works as soon as waste starts to fill the pouch, offering discreet odor eliminating options, (Byram Healthcare, 2020). The Braden Scale has proven to be highly effective in assessing pressure injury risk. It is proven to be reliable and useful in decreasing risks for pressure injury development by utilizing careful implementation through assessment and scoring factors. This tool is evidenced based and many pressure injuries are preventable. Helps in telling nurses to

	up body when moving forward or back on bed/chair.		optimize treatment for the patient, (Nursing CE Central, 2022)

References:

Byram Healthcare. (2020). *5 Ways to Avoid Ostomy Odor*. https://byramhealthcare.com

Gillette Children's. (2024). *Bladder Irrigation- Adult*. https://gillettechilldrens.org

Nursing CE Central. (2022). *Utilizing the Braden Scale*. https://nursngcecentral.com

WebMD. (2024). *Secrets to Gas Control*. https://webmd.com

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: _____