WOC Complex Plan of Care

Name: _____Yvan Fortunat_____ Patient Encounter Date: ____10/31/24_____

Preceptor for Patient Encounter: _____Jeanine Osby_____

Clinical Focus: Wound _x___ Ostomy ____ Continence ____

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
Patient is a 35 year old male, A&OX3 self directing with history of HTN, Heart Disease, DM, Stroke, Anesthesia Problems, morbid obesity, back pain, history of cellulitis, Ht 6'2", Wt 557lb. Patient had had surgery on 8/13/24 for a panniculectomy and scrotoplasty. Due to some respiratory complication, patient remained in the ICU for management until he was stable. He was transferred to regular nursing where he was consulted by urology and internal medicine. Patient was discharged on postop day 9 to be followed by home health. As per patient, since going home, he had suffered numerous dehiscence of his panniculectomy incision. During his follow up outpatient appointment, the PRS team recommended inpatient admission for management of the wound as it was noted to be worsening. Patient denied any other symptoms. He had no fever, chills, nausea, vomiting, diarrhea. Patient was taken duricef at home and confessed he had not been taking care of the wound at all. Patient was admitted with a 16Fr foley catheter on. Folley appears patent, urine is yellow, no cloudiness. The penis is right in the middle of this big sized wound which goes from the pubic area to the fold of the abdominal pannus. Wound is 1cmx16cmx2cm, inferior portion is flush with no	WBC: 9.31 RBC: 4.7 Hemoglobin: 10.9 Hematocrit: 35 Platelet count: 358 Metabolic Panel Sodium: 135 Potassium: 3.9 Chloride: 97 CO2: 26 Glucose: 108 Creatinine: 0.88 Albumin: 13 EGFR: 115 Albumin: 3.8

depth. Four tunnels are noted from right to left #1- 5.5cm, #2- 4.0cm, #3- 5.4, #4-15cm (variation in measurement may be possible depending on if wound is opened a lot or if patient stays in a relaxed position. Wound bed is clean, 95 percent granular tissue with about 5 percent adipose tissue. Wound edges are clean, attached to base. Peri-wound skin is dry and intact. Large Serosanguinous drainage noted from the previous dressing, strong odor is noticeable before cleansing but after wound is irrigated with normal saline, odor is reduced significantly. Peri-skin is cleaned with soap and water, patted dry, bilateral creases under pannus are cleaned with soap and water, dried very well then tuck InterDry BID. 3M Cavilon no sting skin prep used on the edges, Hollihesive strips cut to fit, they are used to frame the wound following the peri-wound skin. Wound bed is irrigated using 20ml syringe and 18g angiocath. White foam is used to fill in tunnels #2, 3 and 4, black foam is cut to fit wound tunnel #1. Piece of non-stick petroleum cover is wrap around penis and foley to prevent suction of the penis when NPWT is on, full spiral pieces of Veraflo foam is used to fill in the wound bed, NPWT connected and set at 150mmhg, 34ml of vashe solution to instill, every 2 hours at medium continuous pressure to be changed 2xweekly Tuesdays, and Fridays. Pain-Tylenol PRN, oxycodone 5mg PRN, duloxetine Pulmonary: patient uses a CPAP at night CV- Continue with ordered medicine (medicine co-management with home medications) GU- 16FR foley catheter-maintenance Nutrition: Carb controlled diet DVTppx: Q8, ICDs Activity: OOB Medications: vitamin D3 5000Units 1tab daily, spironolactone 25mg 1tab daily cefadoxil 500mg BID, carvedilol 25mg MID, sacubitril-valsartan 24-26 mg 1tab daily, torsemide 150mg 1tab daily, duloxetine 30mg 1tab daily, Vit. B12 1000mcg 1tab daily, potassium chloride 40mg 2 tab daily, calcium carbonate 500mg 1tab TID, colace 100mg BID, senna 8.6mg 1tab daily, Benadryl 25mg q6h PRN, Tylenol 1000mg 1tab q6h, oxycodone 5mg q4h PRN, heparin 5000units subcutaneously q8h, NACL 0.9% iv flush 20ml PRN, Jardiance 10mg 1tab daily. Wound treatment for dehiscence surgical wound -Peri-skin: clean with soap and water, pat dry, -Clean bilateral creases under pannus with soap and water, dried very well then tuck InterDry BID.	BP: 112/68 Temp: 98.6 oral Pulse: 76 Resp: 18 Ht: 6’2” Wt: 557lb NO allergies NO wound culture ordered.

-Use 3M Cavilon no sting skin prep used on the edges, Hollihesive strips cut to fit, they are used to frame the wound following the peri-wound skin. -Irrigate wound bed using 20ml syringe and 18g angiocath. -Use white foam to fill in tunnels #2, 3 and 4, use black foam to fit wound tunnel #1. -Place piece of non-stick petroleum cover around penis and foley to prevent suction of the penis when NPWT is on, -Use Spiral pieces of Veraflo foam to fill in the wound bed, -Connect NPWT connected and set it at 150mmhg, 34ml of Vashe solution to instill, every 2 hours at medium continuous pressure. The whole system to be changed 2xweekly, Tuesdays and Thursdays.	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Surgical wound dehiscence Peri-wound fold moist Large amount of exudate Strong smell with removal of dressing **Braden Score** Sensory Perception – Slightly Limited (3) Moisture – occasionally moist (3) Activity – chairfast (2) Mobility –very limited (2) Nutrition – Adequate (3) Friction and Shear – Problem (1) **Total**: 14 – Moderate risk for pressure injuries	-Clean bilateral creases under pannus with soap and water, dried very well then tuck InterDry BID. -Use 3M Cavilon no sting skin prep used on the edges, Hollihesive strips cut to fit, they are used to frame the wound following the peri-wound skin. -Irrigate wound bed using 20ml syringe and 18g angiocath. -Use white foam to fill in tunnels #2, 3 and 4, use black foam to fit wound tunnel #1. -Place piece of non-stick petroleum cover around penis and foley to prevent suction of the penis when NPWT is on, -Use Spiral pieces of Veraflo foam to fill in the wound bed, -Connect NPWT connected and	Peri-wound moisture is minimal No skin breakdown in the fold under the pannus Wound bed is cleaner and fully granular Exudate is getting smaller NPWT is working adequately Wound is closing and getting smaller Patient is placed on the Compella Bariatric bed No new wounds have been documented	-InterDry is an antimicrobial fabric that helps protect patient from moisture and irritation in skin folds Irrigation helps to flush out dirt debris and bacteria which can slow down the healing process. NPWT allows for the eliminination of large exudates, keeps a moist environment for the wound cells to thrive, reduces edema, activates intracellular processes that promote healing by stretching on the cells in the wound bed. Vashe solution is a hypochlorous acid that helps cleanse the wound

	set it at 150mmhg, 34ml of Vashe solution to instill, every 2 hours at medium continuous pressure. The whole system to be changed 2xweekly, Tuesdays and Fridays. Contact the WOC team in case of difficulty with the machine. Turn and reposition patient every 2 hours to prevent pressure injuries Place patient on Hill-Rom Compella Bariatric Therapy System with low air loss surface. Keep head of bed at 30 degrees or less to decrease friction. Follow protocol to management of indwelling catheter Follow nutritionist recommendation for strict calorie intake to manage obesity and diabetes. Monitor blood sugar and treat accordingly as per MD order.	Patient is turned every 2 to 3 hours	bed but also kills a broad spectrum of bacteria and fungi and also disrupts biofilm. Patient has moderate risk of pressure injury as per Braden scale, turning and positioning is an intervention to prevent the formation of pressure injuries. Compella is a bariatric bed with a weight capacity of up to a 1000lb. it is a low air loss surface which helps with prevention of pressure injuries Keeping the head of the bed 30 degrees or less help decrease friction and shear when patient slides down while in bed Indwelling catheter allows for patient to remain dry while wound is healing Nutrition is important for wound healing, diabetic management and obesity management. A balanced diet of proteins, minerals, calories and vitamins in the right proportion is important for wound healing and good health

			Uncontrolled DM is not optimal for wound healing. Because of its action on many systems in the body, DM needs to be controlled to increase the chance of proper wound healing.
Pain: patient complains of pain during dressing changes	Use the pain scale to assess, from 0-10, patient's pain level before starting dressing change. Medicate patient accordingly with prn medication ordered by MD	Patient is medicated 30 minutes before wound treatment	Management of pain can have a great effect on a patient's quality of life as well as on proper wound healing. With too much pain, we may not be able to clean the wound bed properly or use the right treatment for the wound.
	Consult physical therapy	Patient is able to stand up and walk to the bathroom with assistance	Physical therapy can help patient regain strength and mobility.

References:

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: _____