WOC Complex Plan of Care

Name: __ Belinda Chapa_____ Patient Encounter Date: _____8/26/24 – 8/27/24_____

Preceptor for Patient Encounter: _____Jennifer Scheile_____

Clinical Focus: Wound _X_ Ostomy ____ Continence ____

Number of Clinical Hours Today: __12_

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
37 y/o female with SCI admitted for sacral pressure injury wound infection. The wound have been present for 6 months and the patient has been on NPWT for treatment with outpatient wound clinic. The patient has history of MVA in 2021 with injury to thoracic spine. The patient has diabetes type 2 and is obese. History of hypertension and hyperlipidemia. The patient lives with her husband and daughter who are at bedside and provide support for her condition. The patient recently was at an outpatient wound care center where her physician prompted her to go to the emergency department due to malodourous wound that needed debridement of necrotic tissue. The patient has stage four pressure injury to her sacrum and has undergone surgery for debridement of her wound. WOC nurse was consulted for wound vac placement prior to discharge.	**CBC** **WBC:** 22.1 H**(3.4 – 10.8)** **Hgb:** 9.1**L (13.0 – 17.7)** **Hematocrit: 3**0.2**L (37.5 – 51.0)** **Plt count** 355 **(150 – 450)** **RBC: 3.**22L **(4.14 – 5.80)** **Hgb A1c:** 6.1H **(4.8 – 5.6)** **Chem profile** **Creatinine Lvl: 1.1**7 **(0.76 – 1.27)** **EGFR: 60 (>59mL/min/1.73)** **BUN: 2**7 **(8 - 27)** **Sodium: 14**0 **(134 – 144)** **Potassium Lvl** 5 **(3.5 – 5.2)** **Glucose lvl:** 124 **(70 – 99)** **Total Protein: 6.**2 **(6.0 – 8.5)** **Albumin lvl: 3.**6 **(3.7 – 4.7**)

	CRP (<8.0 mg/l) ESR (<OR=20)

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Due to spinal cord injury the patient has altered mobility along with altered bowel and bladder function. Upon assessment the patient is alert and oriented x4. The patient's husband and daughter are at bedside. The primary nurse informed us that the patient will be ready for discharge this afternoon and needed placement of negative pressure wound therapy using KCI vac (which is at bedside), black granufoam, and Dermatac drape with pressure settings at 150mmhg low continuous as ordered by the surgeon. The primary nurse stated that the patient currently has a Hyrdofera Blue dressing on thew wound covered by a large Abdominal pad and medipore tape also ordered by the physician after her surgery. The patient was lying on her back, and we were able to turn her on her side with two person assistance using a log rolling technique. Sacrum pressure injury stage four was cleaned and debrided the day before and is red, moist, and beefy in	The plan for this patient is to apply her wound vac, provide discharge education to her and her family, set up home health nurse visits for wound care, set up home health for IV antibiotic therapy, set up outpatient wound care appointments. Assess pain on 1 out of 10 scale and need to premedicate prior to wound vac change/placement. Plan for 2x daily Braden Scores and interventions being performed. • Sensory perception 3 Slightly Limited. Place appropriate support surface with low air loss bed. Protect bony prominences with Allevyn foam dressings. Offload heels by wearing Prevalon heel protector boots. Use foam wedges for repositioning. • Moisture 1 Constantly	Patient and family members are open and receptive to wound care and discharge information and education. Patient states has no pain. Patient is insensate. Patient's heels have no breakdown. Sacrum is being offloaded.	Braden Scale has been used widely and is a reliable tool for pressure injury risk. The tool has been tested in many settings and with diverse groups of patients and continues to provide consistent results. (Borchert., 2022)

appearance. Wound is not malodorous and has no visible necrotic tissue. The wound edges are attached and there is no undermining or tunneling. The wound measures 11.5 cm x 8cm x 3.5 cm. Currently while taking wound measurements the patient has an incontinence episode of urine. She states that she performs self-catheterizations every 6 hours but that since she came to the hospital the doctors have her taking a diuretic which is increasing her urine production and causes her to have incontinence episodes. Her concern is that her wound vac will not stay on and she may need an indwelling catheter. The patient's bowels are scheduled at night time and states her and her husband have been successful at keeping stool away from her wound with nightly digital stimulation and suppositories. The patient voices her concern about who and when will someone be changing her wound vac. She also states that she recently had home health but that they discontinued services due to her hospital admission and would need to have them re-established. The patient also mentions that she is supposed to have IV antibiotic treatment	moist. Check and change brief/pad every 2 hours. Apply female Purewick system to contain urine in between catheterizations for incontinence episodes. • Activity 2 Chairfast. Place on appropriate support surface such as low air loss bed. Reposition every 2 hours. Wear Prevalon heel protectors. Inspect bony areas frequently. Avoid positioning on medical device. • Mobility 3 Slightly limited. Repositioning every 2 hours. Protect heels using Prevalon boots. • Nutrition 4 Excellent. Encourage intact. Consult with nutritionist. • Friction and shear 2 Potential problem. Place on low air loss bed. Keep the bed flat when repositioning. Head of	Patient is successfully keeping moisture away by using purewick. Heels are intact. There is no breakdown. Positioning is off of medical device (wound vac) or its tubing. Heels are intact. There is no breakdown. Protein and Albumin blood levels are normal. Patient never refuses a meal and is drinking Juven to enhance wound healing. Nutritionist is meeting with patient daily. Patient has no tears or skin issues from friction or shearing.	Part of holistic care in wound care is gathering a list or history of the patients dietary intake and calculate how much protein and calories are they consuming. A nutritionist or a WOC nurse is able to calculate the daily need for optimization. The adult patient with a wound would likely need a higher intake of protein than those

daily at home through her PICC line and no one has come to talk to her about it. During the assessment interview with patient OT came to visit with patient and stated they would come back after wound care is finished with patient. At this point I asked if she needed any Pt or OT services at home and the patient stated not at this time. That she performs all transfers mostly by herself and is "pretty self-sufficient" she stated.	bed at or below 30 degrees. Total: 15 indicating mild risk for pressure injury. Severe risk <9 High risk 10-12 Moderate risk 13-14 Mild risk 15-18 Daily skin assessment with WOC nurse during WOC nurse visits and/or wound vac or dressing changes. Cleanse wound with Vashe wound cleansear and apply KCI negative pressure wound therapy dressing treatment. Place disposable chuck under the patient. • Using 4x4 gauze and Vashe cleanse the wound prior to wound vac application. • Cut the black granufoam into spiral or cinnamon strands. • Apply 3M cavilon to periwound. • Apply window drape dressing around	Heels and bony prominences are intact with no breakdown. Next day wound vac machine is working well at desired pressures. There are no leaks noted. Patient and family verbalize that they have extra drape if needed and verbalized understanding on troubleshooting the vac machine. Patient and family verbalize understanding that if the wound vac is not obtaining a good seal and home health or wound clinic is unavailable they are to remove the wound vac dressing and apply	without a wound. (Evans., 2005)

	periwound using KCI dermatac drape. • Apply bridging predrape to left or right side of patients lateral buttock away from bony prominence. • Starting at the middle of the wound start filling in wound with granufoam in cinnamon roll fashion and bring granufoam out over bridging drape. • Holding black foam in place, use Dermatac drape to cover and secure black foam and extend to cover black foam over the bridging. • Cut quarter size hole at the end of bridge over the black foam and stick connector tubing to the bridge. • Remove all paper backing from the connector. • Turn on kci wound vac and apply settings as directed by physician. • Wait for suction and listen for air leaks. • Apply extra drape if needed to secure leaks.	hydrofera blue dressing to wound covered with large abd pad change daily until wound care or home health can reapply wound vac.	

	Collaborate with case management to establish home health services that are appropriate for wound care and for IV antibiotic therapy.	Case management was able to re-establish care with the home health company the patient had previously. The home health company has reached out to the patient and informed that a WOC nurse is available and they will care for her IV infusions as well. The patient and family verbalize understanding of wound vac changes Mondays, Wednesdays, and Fridays. Mondays with outpatient clinic so the doctor can follow up on the wound and Wednesdays and Fridays with home health.	Patients who have home health wound care provided by WOC nurses have improved stability of their conditions, including wound, ostomy, and incontinent needs. Higher healing rates are noted from care provided by a WOC nurse versus general staff nurses. (Bliss et al., 2012)
	Collaborate with infectious disease doctor to establish IV antibiotic therapy and home health infusion schedule.		
	Consult hospitalist to discuss patient concerns of urinary incontinence episodes.	Patient verbalizes that infectious disease appointments will be weekly to monitor inflammation labs and monitor effectiveness of treatment and infusions at home will be daily.	The infectious disease doctor

	Set up appointment for the patient with outpatient wound care clinic.	Hospitalist doctor came to discuss with patient her incontinence concerns and patient verbalized understanding that an indwelling catheter would only increase risk of infection and will not be needed. That the diuretic was only to be taken for a few days for fluid retention and no longer has to take diuretic after discharge and that she should be able to return to her scheduled emptying routine.	looks at a range of laboratory values weekly that can help monitor the progress of a current infection and the effectiveness of treatment. (Evans., 2005) The (FEUC) female external urinary collection device, purewick that the patient utilized while in the hospital was effective and is first choice for incontinence over an indwelling catheter that could instigate catheter associated urinary tract infection (CAUTI). The risk for bacteria increases each day an indwelling catheter stays in place. (Eckert et al., 2020)

References:

Bliss, D. Z.; Westra, B. L., Savik, K., & Hou, Y. (2013). Effectiveness of wound, ostomy and continence–Certified nurses on individual patient outcomes in home health care. *Journal of Wound, Ostomy and Continence Nursing 40*(2), 135-142 https://doi.org/10.1097/WON.0b013e3182850831

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. 398-400). Wolters Kluwer.

Eckert, L., Mattia, L., Patel, S., Okumura, R., Reynolds, P., & Stuiver, I. (2020). Reducing the risk of indwelling catheter-associated urinary tract infection in female patients by implementing an alternative female external urinary collection device: A quality improvement project. *Journal of wound, ostomy, and continence nursing : official publication of The Wound, Ostomy and Continence Nurses Society*, *47*(1), 50–53. https://doi.org/10.1097/WON.0000000000000601

Evans, E. (2005). Nutritional assessment in chronic wound ware. *Journal of Wound, Ostomy and Continence Nursing 32*(5):p 317-320

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: _____