WOC Complex Plan of Care

Name: ___Catherine Gordon_____ **Date:** ___12/6/2024_____

Clinical Focus: Wound ☒ Ostomy • Continence •

Number of Clinical Hours Today: _8__

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
JJ is a 72-year-old male with a history of Carotid artery occlusion, s/p resection of colon polyps, CAD, HTN, hyperlipidemia, obstructive chronic bronchitis, peripheral vascular disease. Prior to current hospitalization, he smoked 1 ½ packs per day. Patient was admitted on 11/08/24 for bilateral femoral endarterectomy and aortoiliac stenting secondary to coronary artery disease. Prior to admission he was alert and oriented x4, ambulatory up to 50 feet. Post-operatively, he failed extubation twice and received a tracheostomy. MI was suspected and serial troponin levels were drawn. The highest level was 2038, and most recent level was 458 on 11/20/24. After tracheostomy placement, patient was unable to swallow and was placed on NG feedings of Nutren 2.0 with modular addition of ProSource NoCarb Neutral. Currently moving to soft diet, able to complete ¼ of meals consistently. Enteral feedings reduced from 22 hours/day to 10 hours/day with plan to discontinue when patient is consistently eating 50% of meals. Patient is currently able to stand without assistance, and has begun ambulating with physical therapy. Incontinent with liquid stools, foley catheter in place On admission his skin was intact but reddened, and thermograph showed a 3.6-degree increase, which was indicative of deep pressure injury. The wound was initially staged as a 2, and the wound team was not consulted until 11/25/24. Initial evaluation revealed an unstageable wound on the coccyx with base covered by tan slough. WOC nursing consulted to re-evaluate and set plan for wound. Patient up in chair with breakfast tray. NGT in place with bridle, no redness to nares. Patient able to obey simple commands with prompting, able to stand independently with walker. Stated that he has pain in his “seat” but was unable to describe pain. To minimize interruption, assessment was done while patient stood. No dressing in place, small amount of serosanguinous exudate noted on pad on chair. Wound unstageable due to yellow/brown slough covering bed. Edges pale and full thickness. Wound	December 6, 2024 WBC 8.7 HGB 10.0 HCT 30.8 Platelets 316 Protein 6.2 Albumin 2.8 Calcium 8.9 Alk Phos 116 Glucose 78 Creatinine 0.49 Sodium 137 Potassium 4.0 POC Glucose 159

measured 2.5cm L, 2cm W, 0.1cm D. Peri-wound skin reddened and non-blanchable extending 4.5cm circumferentially. Cleansed with Vashe solution, and periwound area covered with Cavilon No Sting skin prep. Applied hydrogel to Allevyn foam and covered wound. Patient tolerated treatment without issue. Denied increased pain during treatment. <u>Current Medications</u> Cilostazol 100mg BID Levothyroxine 25mcg QD Ramipril 10mg BID Atorvastatin 40mg QD Multivitamin 1 QD Aspirin 81mg QD Polyethlyne glycol 3350 17g packet TID Dextrose 15g PRN hypoglycemia Nystatin 5ml PO QID Acetylcysteine 200mg INH QID Pantoprazole 40mg BID Zinc oxide TOP PRN rash Heparin 5000u SQ Q12H Ipratropium 3ml NEB QID Insulin lispro injection SQ Q6H Clopidogrel 75mg QD Quetiapine 25mg QHS Metoprolol tartrate 25mg Q12H Acetaminophen 650mg Q4H PRN pain Thiamine 100mg TID Budesonide 0.5mg INH BID Albuterol 2.5mg INH Q4H PRN shortness of breath Intake (per progress note) 560ml Output (per progress note) 450ml	

WOC Complex Plan of Care

Wound Care recommendations o Cleanse wound with gentle soap and water. Gently dry and apply Hydrogel. Cover with ABD pad. Change daily and if loose or soiled. Wound care to follow. Contact if peri-wound skin breaks down, or if slough separates from wound base. o Maintain Tru-Vue heel protectors to bilateral lower extremities when in bed to offload heels o Air Turn & Position System for bed. Turn every two hours using TAP wedges to minimize pressure over coccyx/sacral region. o Maintain low air-loss bed while in ICU. Place on Stryker low air-loss bed with Isotour blower when moved to step-down unit or medical-surgical floor. o Re-consult with nutrition to evaluate intake, as NG feedings are being limited and patient's protein intake may become impaired.	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Unstageable pressure injury with surrounding deep pressure injury **Braden Score** Sensory Perception – Slightly Limited (3) Moisture – Very Moist (2) Activity – Chairfast (2) Mobility – Very Limited (2) Nutrition – Probably Inadequate (2) Friction and Shear – Potential	1. Change dressing daily or when soiled. Cleanse sacral wound with soap and water. Pat dry Apply Cavilon No-Sting Skin Prep to peri-wound area Apply Kendall Curafil amorphous hydrogel to wound base Cover with ABD pad Notify wound team if peri-wound skin breaks down, if slough	1. Deep tissue injury progressing to unstageable pressure injury. 2. Patient beginning to increase mobility, but continues to spend the majority of time in bed 3. Patient has been significantly malnourished, and was placed on enteral feedings which addressed this by providing appropriate protein, vitamins and minerals as well as increased	1. Soap and water is inexpensive, easily available and has been shown to be more effective than many commercial cleansers. It caused a 30% reduction in bioburden in one study (Oropallo et al., 2024). Liquid barrier over damaged but intact skin will decrease friction and moisture damage to the area. (R. B. Turnbull Jr. MD School of WOC Nursing, 2022)

Problem (2) **Total**: 13– Moderate Risk for Skin Breakdown Existing pressure injuries automatically makes patient very high risk for pressure injuries. It is also important to note that this Braden score is higher than scores in the previous weeks.	separates, or if new exudate is noted. 2. Maintain Tru-Vue heel protectors to bilateral lower extremities when in bed to offload heels 3. Turn every two hours using TAP wedges to minimize pressure over coccyx/sacral region. 4. Maintain low air-loss bed while in ICU. Place on Stryker low air-loss bed with Isotour blower when moved to step-down unit or medical-surgical floor. 5. Re-consult with nutrition to evaluate intake, as NG feedings are being limited and patient's protein intake may become impaired.	calories. However, as he returns to PO intake, he needs re-evaluation and education to prevent further malnutrition.	2. Patient continues to spend much of his time in bed, and considering slow recovery, multiple complications and history, it is reasonable to expect that he will continue to do so. This combined with his history of smoking and peripheral arterial disease create a high risk for pressure injury of the heel. Offloading the heels with protective wraps is more effective than simply resting feet on pillows (Barakat-Johnson et al., 2022) 3. While in bed, utilizing frequent turning with appropriately placed wedges is a standard of care for preventing pressure injuries (R B. Turnbull Jr. MD School of WOC Nursing, 2022). 4. Low air-loss beds for people with impaired skin have been shown to reduce pressure injury occurrence and progression in people who will be spending a large amount of time in bed (R. B. Turnbull Jr. MD School of WOC Nursing, 2022) 5. People with wounds, as well as those with significant illness require increased protein, calories and other nutrients. As the patient moves away from enteral feedings his intake needs to be re-evaluated and monitored (R. B. Turnbull Jr. MD School of WOC Nursing, 2022)

References:

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