WOC Complex Plan of Care

Name: Carol Pero **Date:** 12/06/24

Clinical Focus: Wound • Ostomy ☒ Continence •

Number of Clinical Hours Today: 8

One complex journal is required for *each* specialty in which you are enrolled. 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 enrolled 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 history of Gardner syndrome, desmoids tumors, and complex surgical history including extensive resection of desmoids tumors of the abdominal wall, retriperitoneum, diaphragm, pelvis, and bladder. Patient has also undergone a subtotal colectomy, proctocolectomy with end ileostomy (02/06/24), duodenal repair, end gastrostomy (06/21/24), end jejunostomy (07/22/24) , repair of bladder, takedown of previous J tube, partial adrenalectomy, takedown of multiple enterocutaneous fistulae, evacuation of right retroperitoneal abscess, and repair of left ureter. Patient has had multiple nephrostomy tube exchanges. Other PMH includes multiple positive cultures for various organisms including VRE, MRSA (blood & urine), and Klebsiella pneumoniae (12/04/24 urine); anxiety, DVT during 2010 pregnancy, pyoderma gangrenosum near prior stoma, stage III rectal cancer, leukocytosis, sepsis current, moderate protein-calorie malnutrition/TPN dependent, chronic abdominal pain, bladder leak, pelvic abscess, vesicocutaneous fistula, urethrovaginal fistula. Social History: Patient lives out of state and is married and has four school-aged daughters. A member of the Jewish community accompanies her at bedside as caregiver while	12/04/24 +urine culture *Klebsiella pneumonia* 12/04/24 WBC: 11.0 12/04/24 Lactate: 2.6 12/06/24 Glucose: 240 manual Accucheck (on TPN)-treated with sliding scale insulin 12/06/24 "Lytes stable" Baseline Cr: 0.6-0.8 Hgb : 8.8 Labs: CMP, CBC, Mg, and PO4 every 0400

hospitalized. No history of smoking, alcohol, or drug use. Works as a freelance photographer and was considering returning to school for nursing degree prior to illness. Of note, patient is an experienced ostomate with history of multiple stomas. Currently on bedrest and under palliative care specifically for pain and nausea. Patient is also under transplant team care with intestinal transplant a consideration. New antibiotic treatment initiated 12/06/24 for positive urine cultures taken on 12/04/24. Teaching physical independence with ostomy care in current state is not priority at this time. Importance focused on teaching patient ways to preserve current ostomy pouching systems for improved wear time and instructing nursing staff the same. .	Transfuse for Hemoglobin <7 12/12/24 Repeat vit D, Cu, and Zn

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Alteration in bowel function: end gastrostomy and end jejunostomy. **End Gastrostomy** stoma is located in RUQ and measures 1 1/8” x 2” and protrudes slightly. Stoma is red and moist with mucocutaneous junction intact. Peristomal skin is erythematous and denuded circumferentially. Peri-stomal contour is semi-soft and is concave with deep transverse crease below the stoma. Gastrostomy output is clear mucoid and gastric	Use one piece Coloplast SenSura flat cut-to-fit flange (#15521) with Hollister Adapt CeraRing Regular (#8805) as specified for each below. Prepare for pouch change: * Assemble needed equipment including removing packaging from Domeboro packet, scissors, brava strip paste, Hollihesive, Adapt CeraRing barriers (#8805), Coloplast SenSura Flat Cut-to-Fit Drainable pouch, and Coloplast Brava sheets, and wound care items including	Notes indicate that historically, patient requiring gastrostomy and jejunostomy pouching system changes on average of twice daily while hospitalized due to leakage from fistula openings of suprapubic region. Denuded peri-gastrostomal skin is common finding and degree waxes and wanes. Today pouching system intact at superior aspect and nonadherent at inferior aspect secondary to saturated suprapubic fistula/abdominal dressing, despite use of waterproof tape.	Reduction and/or redirection of moisture is important in managing peristomal skin exposed to excessive drainage. Additional accessory products such as skin barrier wipes, stomahesive powder, barrier strips and rings can aid in prevention and treatment of moisture damage of peristomal skin (Salvadeena & Hanchett, 2022).

contents prior to pouch change today. Currently, pouching is emptied by staff q shift and prn per intake pace. Gastrostomy pouch is connected to night gravity drainage bag.	kerlix roll and waterproof tape. *Cut wedges out of Hollihesive of various sizes to accommodate creases. Cut large ring with slits for gastrostomy opening. *Cut Coloplast sheet into arched strips (or use Brava Elastic Barrier Strips) in preparation to border both pouching systems. * Remove pouching system with push-pull technique *Use adhesive remover as needed. *Cleanse skin with warm water *Thoroughly dry skin **Gastrostomy**: For denuded erythematous peristomal region, apply Domeboro soak, leaving in place x 15 minutes. Apply stomahesive powder followed by 3M Cavilon No-Sting Skin Barrier. Using Hollister Hollihesive wedges, circumferentially apply wedges in petal format. Cut a washer using Hollihesive and make inner radial slits along inner circumference. Secure Hollister Adapt CeraRing Regular (#8805) to aperture of one piece Coloplast Sensura flat cut-to-fit flange (#15521). Frame all sides	Patient states “no one changed pouch or dressing during the night”. Floor nurse states that patient refused change during the night. Conflict of statements above left unresolved. Instead, encouraged patient to alert nursing should suprapubic/abdominal dressing require change when drainage noticed. Notes indicate persistent difficulty in maintaining skin integrity of peristomal skin of end gastrostomy.	Enzymes and acid are secreted by the stomach to digest food (Netsch, 2022).

End Jejunostomy stoma is located in LUQ and measures 1 1/8” x 1 1/2” and is budded. Stoma is light red and moist with mucocutaneous junction intact. Peristomal skin largely intact with only thin rim of erythema that is adjacent and circumferential to the stoma. Peri-stomal contour is semi-soft with deep creases around the stoma with deepest crease toward midline at 8:00 position. Jejunostomy output is thin and bright green to bright yellow prior to pouch change today. Currently is emptied by staff q shift and prn per output pace. Jejunostomy pouch is connected to night gravity drainage bag.	with Coloplast Brava sheet strips. Connect to pouch to tubing utilizing strip of Hollihesive around tubing on pouching side, securing with water proof tape and connecting to gravity drainage bag. **Jejunostomy**: For erythematous peristomal rim, apply stomahesive powder followed by 3M Cavilon No-Sting Skin Barrier. Fill transverse crease with twisted Coloplast Brava strip paste and cover with Hollister Hollihesive wedges at 8:00. Secure Hollister Adapt CeraRing regular (#8805) to aperture of one piece Coloplast Sensura flat cut-to-fit flange (#15521). Frame all sides with Coloplast Brava sheet strips. Connect distal pouch opening to tubing utilizing strip of Hollihesive around tubing on pouching side, securing with water proof tape and connecting to gravity drainage bag. *Encourage patient to monitor suprapubic dressing to prevent overflow invasion into pouching systems. Call for floor nurse to change dressing when moist.		Nutritional absorption of fats, vitamins, proteins, and some carbohydrates take place in the jejunum (Netsch, 2022).

	*Nursing to measure output and record output on I & O form. *Encourage/allow patient to participate in self- care as tolerated. May assist in directing verbally if unable to direct physically. Long term goals: *Wear time 1-4 days. Realistic goal is 1 x day as current frequency is 2 x day due to high volume fistula. *Change suprapubic dressing as needed if moist to prevent pouching system compromise and need for pouching system changes	WOC team called to return in late afternoon today after being seen in a.m. for pouching and dressing changes.	By assisting the patient in identifying and prioritizing objectives in self-care, gains can be made in their self-efficacy (Carmel & Scardillo, 2022).
Alteration in skin integrity: Midline Abdominal Incision: Fistula to lower midline incision just above the pubic region which is draining yellow urine. This vesicocutaneous fistula is comprised of three openings in linear pattern that extends from mid-suprapubic region in 10:00 direction spanning over 4 cm line. Historically known for increased drainage when	**Suprapubic/abdominal dressing**: *Remove dressing and note drainage character and amount. *Cleanse peri-wound/fistula with mild soap and water. Rinse and pat dry. *Apply fluffed kerlix (1/2 roll) into concavity of region. *Cover with ABD pad and secure with mild pressure using waterproof tape.	Drainage continues to saturate existing ordered dressings. May need to consider other management technique such as third ostomy appliance for fistula management while right nephrostomy tube is non-functional.	To contain fistula drainage, dressings or other containment devices such as negative pressure, suction, or pouches all remain options (Nix & Bryant, 2022).

nephrostomy tube not draining. Drainage is yellow with blood tinge at times and is copious in amount interfering with ability to maintain ostomy pouching systems to gastrostomy and jejunostomy sites that are in close proximity. **Alteration in urinary function**: B/L Nephrostomy tubes to gravity drainage. Left nephrostomy tube with dressing to left flank dry and intact. Nephrostomy collection bag full with yellow urine. Securement device in place. Right nephrostomy tube with dressing to right flank dry and intact. Known abnormal finding of absence of drainage noted in right nephrostomy collection bag. Securement device in place.	*Nursing providing irrigation of 10 ml of NSS to each nephrostomy tube twice daily per current physician order. Nephrostomy tube is scheduled to be exchanged by Interventional Radiology q3-4 weeks. Notify physicians if assessment is apart from baseline. Empty nephrostomy collection bag when 1/3 to ½ full. Secure tubing with securement technique per protocol. Be aware if nephrostomy tube is not patent and draining, urine is expected to increase through route of vesicocutaneous fistula.	Per plan of care, both bid nephrostomy tube irrigation and q3-4 week nephrostomy tube changes are ordered out of witness to "severely encrusted" nephrostomy tubes noted on last tube exchange. Ordered frequency increased as a result. Right nephrostomy tube remains without output. Plan for exchange delayed due to current urinary infection. Left nephrostomy tube remains patent for yellow urine. Lack of output persists in right nephrostomy tube. Frequent suprapubic dressing changes required for saturation. Patient is pending right nephrostomy tube replacement when infection resolves.	Flushing of a nephrostomy tube is required in some instances if urine is absent (Fellows & Rice, 2022). A commercial stabilizer for catheters can be utilized for stabilization of nephrostomy tubes (Fellows & Rice, 2022).

Risk for Infection: Positive urine culture (*Klebsiella pneumoniae)* taken on 12/04/24. H/O recurrent urinary tract infections. .	Monitor response of antibiotic for resolution of fever and improvement of other s/s infection. Infectious Disease follows. Notify if s/s infection persist. Continue to monitor s/s infection. Fever, chills, malaise, flank pain and report to physician if affirmative.	IV meropenem and IV daptomycin replaced with IV cefazolin post urine culture and sensitivity results, initiating today, 12/06/24.	Treating infection promptly is vital in patients with intestinal failure (Guillen & Atherton, 2023).
Imbalanced Nutrition: Less than Body Requirements and High Risk of Dehydration. Patient's current nutrition consists of parenteral nutrition for short bowel syndrome 4L PN over 12 hrs with 2 hr taper up, 1 hour down. PN + a lipid emulsion comprising soy oil, MCT, olive oil, and fish oil (SMOF) 1790 kcals/d (31/4 kcals/kg) and 2.37 gm/kg using dosing wt 57 kg. Continue SMOF lipids 250 ml daily. IVF 500-1000 ml 0.9% NaCl x 2 hrs PRN. Vitamin & Mineral Supplements:	Continue Registered dietician services for recommendations in response to labs and physical findings. Continue to allow patient to eat for pleasure adhering to limitations of a single starch po diet, low sugar, and fiber controlled. Restrict fluids to recommended 500 cc. Identify food likes and dislikes with encouragement to consume those that patient prefers that falls within above guidelines to encourage autonomy.	Notes indicate Nutrition Support Team continues to monitor patient's labs and adjusts TPN needs. Continues daily labs: CMP, CBC, Mg, and PO4 every 0400. Selects po comfort food according to orders. Quick return into gastrostomy noted.	Intravenous fluids are required in addition to total parenteral nutrition to maintain hydration and adequate urinary flow (Guillen & Atherton, 2023).

MVI with tralement + additional 7 mg Zn and 0.7 mg Cu daily. Vitamin B12 1000 mcg IM injections monthly. Vitamin D2 50,000 units daily			
Pain: Patient rates pain "3-6" on the Numeric Pain Rating Scale.	Offer patient pain medications as prescribed per protocol. Patient has good knowledge of what is available and time intervals allowed them. Administer pain medication, as indicated. Reassess pain level after 30 minutes. Assess pain prior to pouch and dressing changes using validated pain scale such as numeric (1-10). Monitor fistula site for signs of infection: signs/symptoms for wound infection (increased warmth, redness, WBC level, and pain at site). Infection s/s can increase pain level. Use distraction (discuss what interests patient including past, family, work, hobbies, etc.) to assist with pain management.	Medication record indicates that patient utilizes available pain medications appropriately and nursing provides at proper intervals. Nurse administered pain medication at start of WOC team visit today. Patient spoke to family via telephone, very tearful. Smiling when talking about daughters and her career.	Management of not only physical symptoms during rapidly declining health, but management of psychological, spiritual, and social support is part of a palliative care program (Alshamarri, 2021).

	Assist with position changes for comfort as needed. Encourage movement as able in bed with turning and repositioning.	For pouch and dressing changes, able to move self in bed, lifting hips and turning well.	

WOC Complex Plan of Care

References:

Alshammari, F., Sim, J., Lapkin, S., & Stephens, M. (2022). Registered nurses' knowledge, attitudes and beliefs about end-of-life care in non-specialist palliative care settings: A mixed studies review. *Nurse Education in Practice*, *59*, 103294.

Carmel, J. & Scardillo, J. (2022). Adaptations, rehabilitation, and long-term care management issues. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 201- 222). Wolters Kluwer.

Fellows, J. & Rice, M. (2022). Nursing management of the patient with percutaneous tubes. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 304-315). Wolters Kluwer.

Guillen, B. G., & Atherton, N. S. (2023, July 17). *Short bowel syndrome*. StatPearls. https://www.statpearls.com/articlelibrary/viewarticle/28983/

Nix, D. & Bryant, R. A. (2022). Fistula management. In. J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 283-303). Wolters Kluwer.

Netsch, D. (2022). Anatomy and physiology of the gastrointestinal tract. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management* (2nd ed., pp. 12-28). Wolters Kluwer.

Salvadalena, G. D. & Hanchett, V. (2022). Peristomal skin complications. In J. Carmel, J. Colwell, & M. T. Goldberg (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Ostomy management.* (2nd ed., pp. 250-268). Wolters Kluwer.