WOC Complex Plan of Care

Name: Alexis Buehler **Patient Encounter Date:** December 9, 2024

Preceptor for Patient Encounter: Heather Lucas BSN, RN, CWON

Clinical Focus: Wound ____ Ostomy _X___ 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.

Pertinent Medical/Nursing History	Pertinent lab/diagnostic test results
Age/sex: 62 year old female **PMHx:** hypertension, asthma, GERD, depression, type 2 DM, esophageal adenocarcinoma s/p minimally invasive esophagectomy (MIE) at an outside hospital in December of 2023, now s/o multiple revisions and debridements of her esophagostomy in January, May, August, and September of 2024 **HPI/Surgery:** In October of this year, the patient had an EGD with dilation that showed stenosis at the level of the skin of cervical esophagectomy. She was admit to the hospital at the end of November for surgical intervention with the goal of a therapeutic outcome. She was hospitalized for about a week before going to the OR, and she is now s/p left neck exploration, clavicular reconstruction and sternectomy, cervical esophago-jejunostomy with supercharged free flap, exploratory laparotomy, J-tube removal, lysis of adhesions, g-tube insertion into the remnant stomach, roux-en-y jejunojejunostomy, and bilateral pec flaps. On POD 6 the patient had to return to the OR for a mispositioned g-tube (tip found to be in the abdominal wall). The g-tube was replaced with a larger, 20F tube, and a penrose drain was placed in the abdominal wall exiting through the old j-tube site. Since this return to the OR, bilious contents have been draining from the old j-tube site. **Social history:** The patient lives in a single-family home with her two adult daughters and her granddaughter. She has not worked in over a year since her initial diagnosis and surgical procedures. She has no significant history of alcohol or drug use. She smoked cigarettes for 30 years and quit in December of 2023, just before her esophagectomy. At baseline, she walks with a cane. She identified her family as her strongest support system. Oh my gosh, what a lot of things for someone so young!	Patient has serial CBC, BMP, magnesium, and phosphorous lab draws ordered. While many of her lab values are out of range, they are consistently out of range and there are no dramatic changes in these values that need to be addressed at this time. She is receiving TPN for baseline nutritional needs and is on Q6 blood glucose checks with subcutaneous insulin managed by the glucose management team. Insulin is ordered Q6 to align with blood sugar checks. Blood sugars have been stable and within the defined range of 70-120. Vancomycin troughs are ordered for vancomycin therapy, and renal function is being monitored by the unit pharmacist with no acute concerns. The infectious disease team has provided Vancomycin and all other IV antibiotic therapy recommendations.

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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Patient seen for: new consultation for pouching bilious fluid exiting from old j-tube site with c/f fistula formation; incidentally found a hospital-acquired pressure injury on patient's abdomen underneath the bumper of her new g-tube secondary to the bumper being tightly sutured to the abdomen **LOC:** awake and alert, sitting up in the recliner, watching videos on her phone **Subjective interview:** Patient reports frustration over her multiple hospitalizations and returns to the OR over the past year. She is very seasoned to the healthcare environment and states to the wound care team that she prefers caregivers "who know how to do their job". Wound care team discussed ideas of management for bilious drainage exiting from old j-tube site and patient was agreeable. Reports that her pain is well controlled with PCA. She has been NPO "for a while now" and expressed that she "would do anything to eat a pickle. Even just a sip of pickle juice would be amazing", but also states that she understands why she cannot have anything to eat or drink at this time, even for comfort. **Physical assessment:** Patient is neurologically intact, alert, and oriented. She reports having numbness and tingling in her LLE secondary to a patellar injury she sustained years ago, which is why she uses a cane at baseline. Her abdomen is soft and rounded, and she has active bowel	Please follow plan of care (POC) for both the old j-tube site and the new g-tube site, as outlined below. Following discussion with the patient and the surgical team, wound care nurses removed the sutures from the g-tube bumper and relieved tension at the insertion site. **To G-tube site:** 1) Gently cleanse the site with normal saline moistened gauze, remove any dried drainage or crusting. Allow to dry. 2) Apply 3M Cavilon skip prep to intact skin surrounding tube insertion site. 3) Cut two small rectangular pieces from a 4x4 sheet of Mepilex lite, and gently place under the g-tube bumper to absorb drainage and protect surrounding skin. 4) Stabilize g-tube with a tube anchor to reduce tension and the risk for erosion at the insertion site. 5) Change dressing every other day, or as needed for soilage, saturation, and/or dislodgement **To wound at previous j-tube site:** ***Supplies Needed:* Washcloths 3M Cavilon skin barrier wand Hollister stoma powder Measuring template (find taped to	- The wound and ostomy care team will return daily, Monday through Friday, to assess seal and wear time. Orders will be modified according to patient progress and healing. Wear tine will be at least 3 days (see end of this column for my explanation) - Document all dressing changes in flowsheets for tracking purposes. Most likely not needed in the plan - Notify wound team or primary team if…(& this is a plan not an eval) If the pouching system leaks or if you have any questions or concerns please notify the wound care team. If the wound care team is unavailable, please notify the primary team. - Fistula drainage will be < 200 mL/24 hrs in 6 days (or whatever) - If there is 200 ml or more of measured output from the fistula pouch in a 24 hour period, please notify the wound care team and the primary team.plan - If there is 50 ml or less of measured output from the fistula pouch in a 24 hour period, please notify the wound care team. plan - Please monitor vital signs at routine intervals and document per facility policyreally needed?- - Measure oral intake of fluids and meals and document in the intake and output flowsheet every 6 hours. plan - Empty the pouch when it is half to one-third full, measure output in a graduated cylinder, and document the amount, color, and consistency in the intake and output flowsheet every 6	Suturing the external bumper of a percutaneous tube with excess tension is a known contributor to medical device related pressure injuries (Fellows & Rice, 2022). Amount of effluent is a primary consideration for fistula pouching (Bryant & Best, 2016). Monitoring and maintaining fluid and electrolyte balance is an essential part of fistula care because an imbalance can increase the patient's risk for mortality and morbidity (Nix & Bryant, 2022).

sounds in all 4 quadrants. She is continent of urine and has been having multiple loose BMs. C.diff has been ruled out. She is deconditioned but working with physical and occupational therapy a few times per week. **Wound/site assessment:** A full-thickness wound was found at the site of the previous J tube; the complete assessment of tissue type was limited due to depth and the presence of a Penrose drain sutured to the abdominal wall, exiting the site. Visible tissue is moist, pink/red, and nongranular, and there is a moderate amount of bilious drainage, indicating the need for further focused assessment by the surgical team and diagnostic imaging to rule out fistula formation and/or anastomotic leak. Periwound is slightly denuded with maceration. There is poorly defined moisture-associated skin damage extending laterally from the peri-wound that appears to follow an abdominal crease in the pts LLQ along the path of gravity - per the patient, this is secondary to bilious drainage free-flowing down the patient's abdomen while sitting up in the chair. Newly placed g-tube visualized superior to the old j-tube site. G-tube is sutured tightly to the abdominal wall. Upon further inspection, the wound care team incidentally discovered full-thickness tissue loss with slough underneath the g-tube bumper, which was declared as a hospital-acquired pressure injury secondary to a medical device. The tube was not stabilized with an	patient's white board) Medical adhesive remover spray Eakin Fistula pouch 4.3 x 3 Eakin 4 x 4 square, cut in to strips Scissors **Alternative supplies that may be used:** Durable papertowels or any clean and dry cloth (instead of washcloths) Medline Sureprep No-Sting skin protective barrier wand (instead of Cavilon skin barrier) Coloplast Brava powder (instead of Hollister stoma powder) Medical Adhesive remover wipes (instead of medical adhesive remover spray) Coloplast SenSura Mio PostOp 4" (instead of Eakin Fistula pouch 4.3x3) Coloplast Brava strip paste (instead of Eakin 4x4 square cut into strips) Ok, alternative supplies-not just a different manufacturer of a similar product. No powder? No skin prep? What could you do? ***Steps for pouch change, please read carefully (may refer to photos in most recently filed wound care team note):* 1) Gather supplies, perform hand hygiene and put on gloves. Remove pouch using medical adhesive remover spray 2) Cleanse skin and wound gently with washcloths moistened with warm water. Pat skin dry. -Please do not use premoistened incontinence wipes or soap. This will prevent proper adherence to the abdomen and can lead to leaks from the pouching system. 3) Use pre-made template from wound	hours. plan - While emptying the fistula pouch and during dressing changes, educate the patient on the actions performed and encourage them to participate if they would like. plan - Patient able to empty pouch by POD 3 This column can be challenging but it is where you would write how you know your plan is working... Most of the items above are actually part of the plan	

anchoring device. It was also found to have a significant amount of drainage exiting from the insertion site trapped underneath the bumper, further contributing to the injury.	team (taped to white board in patient's room). Trace the pattern from the template onto the back of the Eakin fistula pouch and carefully cut out the tracing. Save template for next pouch change—write the date on it. 4) Create a crust around the wound site: Apply stoma powder liberally to peri-wound irritation and brush off excess powder. Pat Cavilon skin barrier film over the areas with powder. Allow to dry and repeat once more with a layer of stoma powder and a layer of Cavilon skin barrier film. Allow to dry. 5) Use the cut strips of Eakin 4x4 sheet to fill abdominal creases located at 3 o'clock and 9 o'clock - In the 3 o'clock crease, please place the Eakin strip ***underneath*** the penrose drain. This will help with the seal and adherence. 6) Trim off the edge of the pouch that is close to the g-tube bumper 7) Remove backing from Eakin pouch and line the edges of the cut opening with the remaining cut Eakin strips 8) Carefully apply Eakin fistula pouch over old j-tube opening, including the penrose drain, and gently press to mold into the abdominal skin 9) Place a warm blanket over the patient's abdomen and the appliance to further enhance adherence and provide a better seal. ***Tips for successful dressing and pouching system adherence:*** - Change the pouch every 48 hours and as needed for leakage. Expect 24-48 hours		Skin barrier powders may be used to absorb moisture from denuded skin and create a dry surface. Crusting is used in the case of skin that is severely denuded (Nix & Bryant, 2022). Pectin-based products such as the Eakin sheet (cut into strips) are often used as a physical barrier by filling creases and preventing effluent from leaking out underneath the pouch, as with this patient. These products also help to create a flat landing surface for the pouch to adhere (Nix & Bryant, 2022).

	of wear time. - Replace the pouch following the steps above if the patient reports burning or itching, as this may indicate leakage. Empty the pouch when it is 1/3 to 1/2 full, and have the patient practice this skill. Do not allow the pouch to over fill, as this can lead to leakage. - Never reinforce the dressing. If the pouch is leaking, please change the dressing following the above steps. - Please follow all instructions provided exactly. Do not deviate from this order so that future troubleshooting needs can be focused and successful. - *The primary nurse is responsible for routine dressing changes and overall care of this site.* Additional interventions: - Ambulate the patient short, progressive distances 3 times per day. - Monitor and record strict intake and output as outlined by the surgical team - Monitor blood sugars at routine intervals - Continue nutrition POC outlined by the registered dietician - Explain all care to patient and family, and include them in any decision-making or changes to the POC as it occurs		

References:

Just FYI Alexis, in a Word doc the references are double spaced w a hanging indent. Luckily, pretty easy to do – just select the paragraph box above & see the settings for it that I did to your settings. I just used the special box & the spacing box, otherwise everything was the same!

Best, M., & Bryant, R. A. (2016). Management of draining wounds and fistulas. In R. A. Bryant & D. P. Nix (Eds.), *Acute & chronic wounds: Current management concepts* (5th ed., pp. 541-561). Elsevier. There is a 2024 book now so this reference should not be used

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.

Nix, D., & Bryant, R. A. (2022). Fistula management. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 793-813). Wolters Kluwer.

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Content		Possible Points	Awarded Points	Comments
Summary of Selected Patient	Summarizes pertinent medical and surgical history	2	2	
Assessment	Describe assessment findings	6	6	
	List current products and interventions addressing WOC needs reflective of the specialty scope of practice (wound, ostomy, or continence)	6	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	0	N/A
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	12	
	Propose alternative products. Include generic & brand names	4	1	
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	1	
Rationale	Explain the rationale for identified interventions	6	6	
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1	.8	minor
	Proper grammar & punctuation used	1	1	
	References: See the course syllabus for specific requirements on references for all assignments	1	1	Used one book other than text
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50		28.8	

Additional comments:

Reviewed by: Patricia A. Slachta Date: 12/17/24