

WOC Complex Plan of Care

Patient was febrile on admission temperature 102. Wound culture done was positive for Pseudomonas aeruginosa urine culture was positive for Escherichia coli patient started on IV Ciprofloxacin and meropenem. Patient received 2 units of PRBC during admission.

WOC nurse consulted for wound care. Patient was alert and oriented x 3, patient identify by name and date of birth. Patient verbally agreed to have wound assess. Skin assessment done with RN patient required two person assist to lift abdominal skin to assess wound. The following was noted midline mid abdominal unstageable pressure injury. Wound is open with red, black, brown, yellow tissue in the base and purple, burgundy on the outer periphery. Wound shape is irregular. Wound measures 28cm x 15 cm x 3 cm dept. Edges are intact and surrounding skin is red and blanches with moisture noted. Moderate Serosanguineous, purulent drainage presents on old dressing. Remove gauze dressing, wound cleaned with normal saline then gently pat dry, lightly packed kerlex moistened with VASHE solution, cover with ABD. Lower mid pelvis deep tissue pressure injury, wound is open with red, purple, burgundy tissue in the base. Wound measures 10 cm x 20cm x 0.3 cm , wound is linear no drainage present. Edges are intact and surrounding skin is yellow hue. Etiology of injury is likely pressure secondary to patient's wheelchair and pannus resting on device. Bruise on left upper posterior thigh open to air. Bilateral buttocks red intact and blanches. Bilateral groin Erythema and moisture-associated skin damage (MASD) noted. Skin is moist with mild irritation in the groin folds. No open areas or wounds observed. The skin is intact, but redness and maceration due to moisture exposure are evident. Cleaned bilateral groin using a no-rinse foam cleanser to gently remove excess moisture, Pat-dried the skin thoroughly. Applied InterDry (Antimicrobial fabric) to the bilateral groin areas.

Current Medications and IV drips:

Magnesium oxide 400 mg tabs BID

Meropenem 2000 mg IV Q 8 hours

Ciprofloxacin 400 mg IV Q 12 hours

Sodium Chloride 0.9 % continuous IV @ 50 ml per hour

Lisinopril 12.5 mg daily

Pantoprazole 40 mg daily 6am

Diphenoxylate-atropine (LOMOTIL) 2.5-0.025 mg per tablet take 2 ta Q 6 hrs PRN for diarrhea

Oxycodone IR 5 mg Q 6hrs PRN for pain

Amlodipine 5 mg daily

INR 1.8

Glucose 133

PT/PTT (ordered)

Stool culture: negative

Blood Culture: Negative

Fecal Occult Blood test (FOBT): negative

Urine Culture: positive for Escherichia coli

Wound culture: positive for Pseudomonas aeruginosa gram-negative rods

CT abd/pelvic without contrast - diffuse colonic wall thickening with the greatest involvement seen in the ascending colon, transverse colon, and rectum and Moderate mesenteric fat stranding is noted adjacent to the sigmoid colon, suggesting moderate inflammation likely related to diverticulitis. No evidence of abscess or perforation.

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<p>Heparin 5000 unit SQ every 12 hours</p> <p>I/Os Intake 2819.2 Output 1500 Stool x 2</p> <p>Wound Care Recommendations:</p> <p>Midline mid abdominal unstageable pressure injury- clean wound with normal saline, pat dry, lightly pack wound with kerlex moistened with VASHE and cover with ABD change dressing daily or as needed</p> <p>-Lower mid pelvis- Deep tissue pressure injury – clean wound with normal saline and gently pat dry , apply Urogtul contact layer over wound and cover with ABD. Change dressing daily or as needed</p> <p>-Place interdry textile AG sheet in a skin fold bilateral groin . Allow 2-3 inches to overhand to wick moisture. Change daily and as needed when soiled</p> <p>-Apply Citiric-Clear to perianal area and bilateral ischium/ left posterior thigh TID and as needed</p>	
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Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Midline mid abdominal unstageable pressure injury Lower mid pelvis- Deep tissue pressure injury	- clean wound with normal saline, pat dry, lightly pack wound with kerlex moistened with VASHE and cover with ABD change dressing daily or as needed - clean wound with normal saline and gently pat dry, apply Urogtul contact layer over wound and cover with ABD. Change dressing daily or as needed. - Place interdry textile AG sheet in	-Improvement in the appearance of wound edges are becoming more defined with less undermining - Reduction in wound exudate	Normal saline is a non-cytotoxic solution that helps clean the wound, removing debris and bacteria without causing further tissue damage. Patting the wound dry avoids unnecessary trauma to the fragile tissue. Kerlex, moistened with VASHE (a wound cleanser), helps to provide a moist wound healing environment, which has been shown to promote granulation tissue formation. The

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<p>Bilateral groin redness</p> <p>Bilateral buttock redness</p> <p>Braden Score Sensory Perception – Slightly Limited (3) Moisture – Often Moist (2) Activity – Chairfast (2) Mobility – Very Limited (2) Nutrition – Adequate (3) Friction and Shear – Problem (1) Total: 13 – Moderate Risk for Skin Breakdown</p>	<p>a skin fold bilateral groin. Allow 2-3 inches to overhand to wick moisture. Change daily and as needed when soiled</p> <p>- Apply Citric-Clear to perianal area and bilateral ischium/ left posterior thigh TID and as needed</p> <p>Tru-View heels protectors to bilateral lower extremities to off load heels while in bed</p> <p>Maintain Comfort Glide patient repositioning system with turning wedges to off load patients coccyx/ishium every 2 hours</p> <p>Please order a seat cushion Oracle # 1066990 for patient when up in chair</p> <p>Place on Bariatric air loss bed</p> <p>Wound care team will continue to follow up on patient status. Please re-consult wound care team sooner if wound worsens.</p>	<p>Wound healing is progressing, with a reduction in size, healthy granulation tissue formation</p> <p>Infection is resolving as indicated by improved drainage and no systemic or local infection signs patient afebrile since admission.</p> <p>Healthy, intact skin around the wound with no new areas of breakdown.</p> <p>Effective offloading of pressure points, leading to prevention or reduction of pressure injuries.</p>	<p>ABD pad acts as an absorbent dressing, protecting the wound from external contaminants while allowing for fluid absorption and preventing secondary infection. This approach helps prevent further skin breakdown and promotes wound healing.</p> <p>Urogtul is a gentle contact layer that provides a non-adherent barrier to the wound bed, reducing mechanical trauma during dressing changes and maintaining a moist environment for optimal healing. It is suitable for deep tissue injuries, as it reduces friction while allowing for the wound to breathe and absorb exudate.</p> <p>Interdry AG is a textile sheet embedded with silver to help manage moisture-associated skin damage (MASD) and to prevent further maceration. Silver has antimicrobial properties that help reduce the risk of infection. By placing it in the skin folds, the Interdry sheet absorbs moisture and maintains a dry environment, which is critical for healing and preventing further skin irritation.</p>
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			<p>Citrus-Clear is a skin protectant and barrier ointment designed to protect delicate skin from moisture and further irritation, particularly in areas at risk for pressure injuries.</p> <p>Tru-View heel protectors are designed to offload pressure from the heels and protect the skin from pressure injuries. Given that the patient is at moderate risk for skin breakdown (Braden score of 13), heel protectors are essential in preventing the development of heel ulcers, which are a common site for pressure injuries. The protectors help reduce pressure and friction on the heels, promoting circulation and decreasing the likelihood of ischemia in these vulnerable areas.</p> <p>Regular repositioning every 2 hours is a key preventative measure to reduce the risk of pressure injury development, particularly on the sacral and ischial areas.</p> <p>The Oracle seat cushion is</p>
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			<p>designed to distribute pressure evenly across the pelvis and thighs, reducing pressure points when the patient is seated.</p> <p>The bariatric air loss bed helps reduce pressure on high-risk areas by redistributing weight and enhancing airflow to the skin.</p>
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References:

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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: _____