

WOC Complex Plan of Care

Insulin Regular human injection (short acting) SQ before meal (see sliding scale)
fentanyl 25-50 mcg injection IV q2hr as needed for pain
Pantoprazole 40 mg injection 40 mg IV daily at 6 am
Clindamycin IVPB 900 mg in D5W 50 ml IV Q 8 hrs
Lactated ringers IV 75 ml/hr continuous
Amlodipine 10 mg tab daily
Azelastine 0.1% nasal spray
Cetirizine 10 mg tab once daily
Cyanocobalamin vitamin B-12, 5000 mcg cap once daily
Levofloxacin 750 mg tab once daily
Mirtazapine 15 mg tab at bedtime for sleep
Oxycodone 5 mg Q6hr for pain level 7- 10
Acetaminophen (Tylenol) 500 mg Q 6 hrs for mild to moderate pain

Allergies: Penicillin, metoprolol, Levothyroxine, diltiazem

Upon assessment, the patient was lying in bed, alert, awake, and oriented to person, place, and time. Two patient identifiers (name and DOB) were used to confirm identity. The patient consented to the skin assessment and was able to assist with repositioning for the provider. The patient reports discomfort, stating, “It burns down there when I pass stool.”

Inspection of the perineal area, extending up to the gluteal crease and onto the coccyx, revealed numerous red, partial-thickness open wounds. The wound pattern was irregular with intact but irregular edges. The surrounding skin was dry and intact. These findings are consistent with irritant contact dermatitis, likely related to previous fecal incontinence and leakage from an external urinary catheter.

Patient was educated on the importance of calling for assistance when having a bowel movement or if experiencing an accident. She was reminded to notify staff immediately for cleaning to prevent further skin breakdown. Citric-Aid paste was available at bedside, and the patient

Hem 38.9
LDH 408
Fibrogen 645
Platelets 9
Ferritin 1593
TIBC 122
Haptoglobin 443

Count Culture: positive for
Staphylococcus aureus (MRSA)

CXR- negative

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confirmed staff has been using it after each episode of incontinence.

The patient reported weakness on admission and difficulty getting out of bed. However, she confirmed she has been feeling stronger with physical therapy and occupational therapy. The patient stated she will call staff for assistance when needing to use the bathroom.

On physical exam, the left neck internal jugular (IJ) catheter site was assessed, with the surgical pressure dressing in place. The site was clean and dry. The stage 3 coccygeal pressure injury showed pink, intact skin, consistent with healing. Maculopapular rash on the chest, characterized by red, flat spots.

. WOC Services to follow and continue to provide continence support.

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
<p>Incontinence Associated Dermatitis</p>	<ul style="list-style-type: none"> - Clean the skin with bath wipes and no-rinse foam cleanser. Pat the area dry thoroughly. Lightly sprinkle Stomahesive powder over the affected area and gently brush off any excess powder. Apply Desitin barrier ointment to the perineal area BID (twice a day) and PRN (as needed) following episodes of incontinence. 	<ul style="list-style-type: none"> - initially treated with Citric-Aid paste. Despite this intervention, the IAD worsened from dark discoloration to moist, shiny, red irregular patches well-defined borders, superficial erosions (weeping sores) due to Significant skin breakdown, open wounds, and erosion requiring a change in the treatment regimen to Stomahesive powder and Desitin. <p><u>Alternate treatment</u></p>	<ul style="list-style-type: none"> - There is no data to indicating one skin protectant is superior to another (Ermer-Seltun & Engberg, 2022, p. 350). Stomadhesive powder is designed to absorb excess moisture, which is a significant factor in the development and worsening of IAD. When applied to the affected area, it helps keep the skin dry

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<p>Stage 3 pressure injury coccyx</p> <p>Left neck surgical site.</p> <p>Maculopapular rash Chest</p> <p>Braden Score Sensory Perception – No Impairment (4) Moisture – Constantly moist (1) Activity – Chairfast (2) Mobility – No limitation (4) Nutrition – Adequate (3) Friction and Shear – Problem (1) Total: 15– Mild Risk for Skin Breakdown</p>	<ul style="list-style-type: none"> - Continue to use Citric-Aid paste as needed for skin protection for healed stage 3 pressure injury - Turn and reposing Q 2 hours. - Off load using wedges - Left neck surgical site leave pressure dressing in place surgical team to follow up - Continue dermatology order apply Aquaphor to rash to prevent further dryness and irritation. <li style="padding-left: 40px;">-Avoid diaper and change external catheter a least once per shift and PRN when saturated - Continue dietitian recommendation for a protein-rich diet, vitamins and continue hydration - Use TruVue heel protector to bilateral lower extremities. - Continue to monitor perineal skin, addressing any further signs of irritation or 	<p>Using warm moist washcloth BID spray Baza cleanse & Protect lotion . Gentle clean peri area from front to back , pat dry , gently spray another layer of Baza cleanse lotion and apply thin layer of Critic Aid Clear. This alternative option reduce pain with dressing removal and allow staff to assess skin.</p>	<p>by absorbing the moisture from urine or feces, thus preventing further maceration (softening) of the skin. Desitin is a thick barrier ointment that contains zinc oxide, which is a well-known and effective ingredient for creating a protective layer over the skin. Zinc oxide helps to shield the affected area from further exposure to moisture, urine, and feces, which are the main culprits in the development of IAD (Wang et al., 2023).</p> <p><u>Alternative treatment</u> Baza cleanse & Protect lotion provides mild cleaning and a breathable barrier and moisturization. Its PH balance help maintain the natural acid mantle of the skin its also CHG compatible. Applying Critic Aid Clear form a protective barrier that make it visually possible to assess the skin for further breakdown. Since the patient is complaining of pain this option is less painful to remove than a thick layer like desitin.</p>
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	<p>breakdown.</p> <ul style="list-style-type: none"> - Reaffirm education regarding timely assistance for bowel movements and accidents to minimize skin breakdown. - Follow up with PT/OT to assess progress in mobility and functional independence - Re-assess pressure injury sites daily, including coccyx area, for signs deterioration. - Continue PRN pain medication as needed - Create a toileting schedule with patient. - Clean patient immediately after any incontinence episode - Consult case management to assess the patient's family or caregiver support to ensure that they can assist with care tasks, including wound care, toileting assistance, and monitoring the patient's overall health. 		<ul style="list-style-type: none"> - Even though the Stage 3 wound has healed, the skin around the area may still be fragile and at risk for breakdown due to moisture, friction, or further pressure. Citric-Aid paste can provide a protective barrier to safeguard the newly healed tissue from irritation caused by friction, perspiration, or continued incontinence. The skin at the site of a healed pressure injury is often thinner and more susceptible to damage Glass et al., 2021). <p>Repositioning the patient every two hours is essential for preventing further pressure and skin breakdown, particularly in areas at risk for pressure injuries. Regular repositioning helps relieve pressure on vulnerable areas and ensures adequate circulation, which is vital for maintaining skin integrity (WOCN Society, 2022)</p> <p>Wedges help offload pressure from the sacral and coccygeal regions, as well as the heels, minimizing the risk of further skin</p>
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	<ul style="list-style-type: none"> - No further visit plan by wound care team. Please reconsult would care if the need arise 		<p>breakdown in patients with existing pressure injuries. Offloading pressure aids in improving circulation and prevents the development or worsening of pressure injuries (Wang et al., 2023).</p> <p>Continuous monitoring of the perineal area is crucial for early identification of any changes in skin integrity. Prompt intervention can prevent the progression of IAD and reduce the potential for further breakdown. Addressing early signs of irritation ensures timely management and improves outcomes for the patient (Wang et al., 2023).</p> <p>Patient education is critical to prevent further incontinence-associated skin damage. Ensuring the patient understands the importance of calling for assistance after bowel movements or accidents minimizes the duration of exposure to moisture, preventing further irritation and breakdown (Glass et al., 2021).</p> <p>A structured toileting schedule</p>
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			<p>helps manage incontinence episodes and reduce the duration of exposure to moisture, thereby minimizing the risk of IAD. This proactive approach enables timely interventions and reduces the burden of uncontrolled incontinence (WOCN Society, 2022).</p> <p>Prompt cleaning after each incontinence episode is critical in preventing further skin irritation and breakdown. Fecal and urinary incontinence are major risk factors for IAD, and immediate cleaning prevents prolonged exposure to harmful substances, thus protecting the skin (Glass et al., 2021).</p>
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References:

Comfort Plus Online. (n.d.). *Coloplast Critic-Aid Thick Moisture Barrier Skin Paste*. Comfort Plus Online. Retrieved January 7, 2025, from <https://www.comfortplisonline.com/coloplast-critic-aid-thick-moisture-barrier-skin-paste>

Ermer-Seltun, J. M., & Engberg, S. (Eds.). (2022). *Wound, Ostomy, and Continence Nurses Society core curriculum: Continence management* (2nd ed.). Wolters Kluwer. ISBN# 9781975164546

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Glass, G. F., Jr, Goh, C. C. K., Cheong, R. Q., Ong, Z. L., Khong, P. C. B., & Chan, E. Y. (2021). Effectiveness of skin cleanser and protectant regimen on incontinence-associated dermatitis outcomes in acute care patients: A cluster randomised trial. *International wound journal*, 18(6), 862–873. <https://doi.org/10.1111/iwj.13588>

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Wang, J., Ma, L., Zhou, D., & Yu, B. H. (2023). Meta-analysis Investigating the Efficacy of Liquid Dressing and Ostomy Powder for the Treatment of Incontinence-Associated Dermatitis. *Advances in skin & wound care*, 36(9), 481–485.
<https://doi.org/10.1097/ASW.0000000000000016>

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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: _____