

WOC Complex Plan of Care

Name: Alexis Faria Patient Encounter Date: 01/24/2025

Preceptor for Patient Encounter: Adam Shaw

Clinical Focus: Wound X Ostomy 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.

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 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
<p>54 year old female being seen today for wound vac change. Patient is “s/p exploratory laparotomy, partial gastrectomy, incision and debridement of abdominal soft tissue infection”. Past medical history includes DM2, end-stage renal disease, hidradenitis, pulmonary hypertension. Patient recently underwent triple valve repair in early December. Patient had g-tube which was leaking into subcutaneous tissue causing tissue infection. Patient currently admitted to ICU, is on ventilator and CRRT. Patient with trach and new feeding tube in place. Per chart review patient also with stage 4 pressure injury to the sacrum and with two open wounds to mid sternal area and LUQ of abdomen. Patient with foley and FMS for containment of output and strict management of I&Os – per nursing. Patient nonresponsive – family coming in later to have meeting to discuss goals of care for patient.</p> <p>WOC nursing consulted for abdominal wounds and wound vac management. Wound care team is consulted for pressure injury to sacrum. Both teams at bedside at this time. Patient turned for wound care to assess sacrum. Old dressing removed. Noted moderate amounts of</p>	<p>N/A</p>

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serosanguinous drainage. Wound cleansed with wound cleanser. Wound is odorous. Wound is 13 cm X 10 cm x 7 cm. Wound bed does have bone and muscle exposure. Wound bed is mostly with slough and moist eschar. Vashe solution used to moisten gauze and used to fill wound bed then covered with ABD. Patient mostly likely not a candidate for surgical debridement due to health status, wound team states they will follow up after goals of care discussion for plan moving forward.

Patient repositioned and wound vac turned off to abdomen. SensiCare wipes used to remove draping and 4 pieces of black foam removed from two wound beds and bridge. Wounds both cleansed. Midline wound measures 12 cm x 5.1 cm x 2.4 cm with tunneling at 12 o'clock 1.2 cm. Wound bed 80% adipose tissue and 20% slough. LUQ Wound measures 10.4 cm x 30 cm x 2.7 cm with undermining present from 11-2 for 3.2 cm and from 5-7 for 3 cm. Wound bed is with 90% adipose tissue and 10% necrotic. Periwound is intact.. Skin barrier used to prep periwound skin. Draping used to cover periwound in picture frame fashion. Contact layer placed in sternal wound and to lateral portion of LUQ wound for areas of slough where unable to determine depth and underlying tissue damage. 4 pieces of black foam used (1 in sternal wound, 3 in LUQ wound). Wounds bridged together. Draping used to secure all foam and quarter sized hole cut and wound vac tubing applied. Wound vac turned on and set to -125 mmHg. Suction continuous. No seal leaks present at this time.

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Stage 4 pressure injury: Wound team following. -bone exposure -high percentage of slough in wound bed Braden score of 10 Patient high risk for breakdown	Wound care plan: 1) Remove old dressing and cleanse wound with wound cleanser 2) Use Vashe to moisten gauze and use to gently fill wound bed to skin level 3) Cover with ABD 4) Change BID 5) Re-consult wound team if	Decrease in devitalized wound tissue Decrease wound odor	Hypochlorous acid has been shown to drastically decrease odor and has been proven to rapidly decrease necrotic tissue in wounds (Mallow et al., 2024).

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<p>Abdominal wounds: Wounds with scant serous drainage Exposed subcutaneous tissue No organ or muscle exposure</p> <p>Patient with FMS</p> <p>Patient with Foley catheter</p>	<p>wound is worsening</p> <p>Use critic aide clear to periwound</p> <p>Wound prevention: Patient on specialty surface Turning and positioning wedges in place; turn and reposition patient every 2 hours and offload boney prominences</p> <p>Maintain FMS to decrease stool leakage into wound as long as stool are liquid</p> <p>Continue dietary recommendations for tube feed and monitor for leakage</p> <p>Abdominal wounds:</p> <ol style="list-style-type: none"> 1) Use Convatec SensiCare wipes to remove draping 2) Remove foam – if foam is adhering, moisten with saline for removal 3) Cleanse wound 4) Drape periwound in picture frame fashion 5) Use Urgotool contact layer to cover areas with slough where depth can not be determined 6) Use black foam to fill wounds and bridge to 	<p>Periwound will be without additional skin breakdown</p> <p>Patient will not acquire additional pressure injuries</p> <p>FMS will keep stool contained and aide in wound healing</p> <p>Wound vac will promote granulation tissue formation</p>	<p>Moisture barriers can assist in preventing periwound moisture associate skin damage (PVMASD). Effective in wounds with nonadherent dressings (Thayer et al., 2022).</p> <p>Repositioning includes manually moving the patient to alleviate pressure to an area of the body. Pressure injury prevention programs should include a repositioning schedule (Borchert, 2022).</p> <p>Intra-anal bowel management systems are used to divert liquid stool into a closed system to aide in perianal skin protection (Callahan & Francis, 2022).</p> <p>Wound vac application can promote healing in complex wounds by removing exudate and debris. Wound vac can promote creation of granulation tissue in a short time (Brindle & Creehan, 2022).</p>
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	connect both wounds 7) Cover foam with draping to secure and cut quarter sized hole in draping to apply wound vac tubing 8) Turn wound vac on to -125 mmHg suction		
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References:

Borchert, K. (2022). Pressure injury prevention: Implementing and maintaining a successful plan and program. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nursing Society core curriculum: Wound management* (2nd ed., 395-423) Wolters Kluwer.

Brindle, T. & Creehan, S. (2022). Management of surgical wounds. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nursing Society core curriculum: Wound management* (2nd ed., 737-774) Wolters Kluwer.

Callahan, L. L. & Francis, K. (2022). Fecal incontinence: Pathology, assessment, and management. In J. M. Ermer-Seltun & S. Engberg (Eds.), *Wound, Ostomy, and Continence Nursing Society core curriculum: Continence management* (2nd ed., 484-519). Wolters Kluwer.

Mallow, P., Black, J., Chaffin, A., Couch, K., Faust, E., Fernández, L., Gallagher, K., Lam, L., Niezgoda, J., & Weir, D. (2024). The economic and quality effects of wound cleansing with pure hypochlorous acid: Evidence-based evaluation and clinical experience. *Wounds: A Compendium of Clinical Research and Practice*, 36(10). <https://doi.org/10.25270/wnds/24101>

Thayer, D., Rozenboom, B. J., & LeBlanc, K. (2022). Prevention and management of moisture-associated skin damage (MASD), medical adhesive related skin injury (MARS), and skin tears. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nursing Society core curriculum: Wound management* (2nd ed., 322-353) Wolters Kluwer.

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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: _____