WOC Complex Plan of Care

Name: _____Jane Frances Nassaka_____ Patient Encounter Date: ___02/13/2025_____

Preceptor for Patient Encounter: ____Elizebeth Kulling_____

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
M. S. is a 62-year-old male with a medical history that includes morbid obesity, hypertension, A-fib managed with Eliquis, heart failure, chronic respiratory failure, and status post tracheostomy (performed 1/15/2025). He also has a PEG tube insertion (1/15/2025), an open jejunostomy (1/22/2025), a transient ischemic attack, and a recent AKI requiring hemodialysis in November 2024. He has type 2 diabetes mellitus treated with insulin (A1C of 7.2% as of October 2024). The patient was admitted from an outside hospital due to concerns about fascial dehiscence and multiple enterocutaneous fistulas near the sleeve gastrectomy site and open jejunostomy tube. He required TPN feeds. Upon admission, he was evaluated for further management of the enterocutaneous fistulas. On examination, he had mild tenderness without signs of peritonitis and a large enterocutaneous fistula suspected to originate from the GI tract to the midline incision and another opening around the jejunostomy. Additionally, the patient had an unstageable pressure injury on the sacrum and bilateral buttocks,	February/13/2025 WBC 18.51 HB 9.3 HCT 30.6 Platelets 454 INR 1.1 aPTT 24.8 Sodium 139 Potassium 4.6 Chloride 104 CO2 24 BUN 30 Creatinine 0.76 Glucose 213

as well as abdominal wound dehiscence with necrotic tissue. The patient underwent debridement of the necrotic tissue of the abdominal wound on 2/12/2025. A CT of the abdomen was performed on the same day. WOC nursing consultation was requested for the patient. Upon examination, the patient was found resting in bed and spontaneously opened eyes and responded to questions by nodding. The patient's abdomen appeared obese with a large pannus. It was soft, though the patient grimaced during deep palpation on the right side. A midline incision with staples was observed, with the inferior portion open, exposing bowel and yellow-gray and green output in the drainage bag. The Jejunostomy tube was in place, with significant green drainage around the insertion site. The left lateral abdominal wall displayed induration and blanching erythema. An indwelling urethral catheter was draining yellow urine, and 300cc of clear urine was present at the time. When the patient was turned, an unstageable pressure injury was noted on the sacral and buttocks areas, with moderate serosanguineous drainage on the dressing. The wound was cleansed with normal saline, it measured 11cc in length, 15.5cc in width, and 0.3cc in depth. The wound bed was covered by 60% slough. Hydrogel was applied to the wound bed, followed by a contact layer (Restore), and an ABD pad was placed and secured with transparent film. The perianal area was cleansed with soap and water, patted dry, and Desitin barrier cream was applied. A midline fistula was identified in the center of the wound, producing green effluent. The wound was cleansed with normal saline, patted dry, and stomhesive powder was applied to the denuded skin. Excess powder was removed, and 3M Cavilon skin prep was applied. Hollihesive wedges were placed around the peri-wound area, with stomhesive paste used to caulk the seams. An Eakin Teardrop pouch, with a window cut to the maximum size, was attached to the gravity drainage bag and secured with Hy-Tape. The wear time for this pouch was 3 days and PRN At the 9 o'clock aspect of the wound in the lower left quadrant, a fistula was leaking around the jejunostomy tube. The surrounding skin was erythematous and denuded, draining serosanguineous	Calcium 7.7 Magnesium 1.9 **Wound culture results:** Showed the presence of Pseudomonas, Enterococcus faecalis, and an ESBL strain, which were sensitive to daptomycin and meropenem. Additionally, fungal septate hyphae were identified, as sensitive to amphotericin B. The CT scan of the abdomen revealed the presence of fluid and gas in the subcutaneous tissue of the left abdominal wall. It also showed a ventral abdominal wall dehiscence, with protruding fat, small bowel, and colon. Additionally, a fistula was identified between the bowel and the midline wound bed.

and green effluent. Stomhesive powder was applied to the denuded skin, excess powder removed, and 3M Cavilon skin prep was used. Hollihesive wedges and stomhesive paste were applied around the peri-wound area to seal the seams. The Eakin pouch was applied horizontally with a window cut to the maximum size, connected to the gravity drainage bag, and secured with Hy-Tape. The wear time for this pouch was also 3 days and PRN

Current medication and IV GTTS:

Dextrose 10% 12.5g bolus IV PRN
Potassium chloride 20mEq/100ml IV PRN
Magnesium sulfate 2g IV PRN
Lactate ringers 75ml/hr IV continuous
Insulin regular subcutaneous Q6hr PRN
Piperacillin-tazobactam (Zosyn) 3.375g IV Q6hr
Daptomycin 1150mg IV Q24hr
Enoxaparin (Lovenox) 40mg s/c Q 12hr
Ipratopium 3ml inhalation QID
Metoprolol 5mg IV Q4hr
TPN 70ml/hr

Wound Care Recommendations:

- **Pressure Injury (Sacral and Buttocks Area):** Normal saline, Hydrogel to the base of the wound. ABD dressing and secure with transparent tape.
- **Perineal Care:** Gently cleanse with soap and water, Desitin barrier cream.
- **Foley Care:** Cleanse with soap and water, and pat dry.
- WOC nursing will continue to monitor the patient. Reach out if there are any concerns or questions.

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
• Unstageable sacral, buttocks pressure injury: • Periwound maceration. • An enterocutaneous fistula extending from the gastrointestinal tract to the abdominal midline incision, along with another fistula located in the left lower quadrant near the jejunostomy. **Braden Score** Sensory perception – Slightly limited (3) Moisture – Constantly moist (1) Activity – Bedfast (1) Mobility – Very limited (2) Nutrition – Adequate (3) Friction – Problem (1)	**Pressure Injury (Sacral and Buttocks Area):** **1.** Cleanse with normal saline, gently pat dry, and apply Hydrogel to the base of the wound followed by Urgotul contact layer. Then, apply an ABD dressing and secure with transparent tape. Change the dressing every other day or as needed when soiled.	Reduction in non-viable tissue and drainage, with the wound showing signs of healing and decreasing in size.	**1**.Normal saline has the same concentration as the body's cells and blood. This makes it gentle on tissue and reduces the risk of cellular damage during wound cleansing. Saline also helps remove debris, bacteria, and exudate from the wound surface without causing further irritation or harming healthy tissue (Jaszarowski & Murphree, 2022). Hydrogel creates a moist environment for the wound and supports autolytic debridement, which helps with cell migration and tissue healing while also alleviating pain. The Urgotul contact layer minimizes friction and prevents the dressing from sticking to the wound bed, yet it remains porous to allow exudate to pass through to the secondary dressing, improving comfort and making dressing changes easier (Jaszarowski & Murphree, 2022).

Total score: 11			ABD dressings absorb exudate and offer a protective barrier, while the transparent film secures the dressing and allows for easy monitoring (Jaszarowski & Murphree, 2022). **Alternative: Vashe wound cleanser, calcium alginate to the wound, border foam.**
	2. Perineal Care: Gently cleanse with soap and water, pat dry, and apply Desitin barrier cream after each bowel movement and twice daily. Apply Inter-dry to skin folds, extending about 2 inches beyond the folds. to prevent moisture accumulation.	Dry, intact perineal skin with no signs of irritation or maceration.	**2.**This routine prevents irritation, protects against moisture and contaminants, and maintains skin integrity by forming a protective barrier, reducing the risk of infection or breakdown. (Thayer et al., 2022). Inter-dry prevents moisture accumulation.
	3. Foley Care: Maintain foley, cleanse the insertion site with soap and water, pat dry. Monitor and document urine output, including color, consistency, and odor. Ensure the catheter bag is positioned below the bladder but off the floor.	No contamination of the sacral wound by urine, preventing infection and skin breakdown. Continuous, unobstructed urine drainage, with the catheter bag positioned correctly to ensure proper drainage. No signs of urinary tract infection (e.g., fever, chills, cloudy urine) due to proper hygiene, catheter positioning, and monitoring of urine output.	**3**.Foley care aims to prevent CAUTI by ensuring proper hygiene and positioning of the catheter. Keeping the catheter bag below the bladder prevents urine backflow while ensuring it's off the floor reduces contamination risks. Maintaining the catheter also helps manage moisture, preventing urine from contaminating the sacral wound.

	4.Turn and reposition the patient every 2 hours from right to left. Ensure the patient is kept off the sacral area and ischium using wedges behind the back to avoid pressure on the sacral area, and a pillow between the legs. Apply Tue-Vue heel protectors to both lower extremities to float the heels while in bed	Nurses report patient being repositioned every 2 hours, with no new pressure injuries forming.	**4.** Frequent repositioning prevents prolonged pressure on vulnerable areas, reducing the risk of pressure injuries. Use of wedges behind the back helps relieve pressure from the sacrum, and ischium. Pillows between the legs help relieve pressure between the knees and ankles, (Mackey & Watts, 2022). By offloading the heels, Tue-Vue heel protectors decrease the likelihood of ulcer formation (Borchert, 2022). **Alternative to True -Vue: pillows under calf to float heels**
	5.Maintain the head of the bed at 30° to decrease friction and shear. **6**.Ensure the patient remains on a bariatric bed to accommodate their needs.		**5**.Keeping the head of the bed elevated to 30° minimizes shear forces and friction, which are significant contributors to pressure injury formation (Borchert, 2022). This position reduces the gravitational forces acting on skin and tissue, reducing friction during movement. **6**.Bariatric beds are specifically designed to support the weight of obese patients and reduce the risk of pressure injuries. They help provide

			optimal positioning and redistribution of pressure across the body (Mackey & Watts, 2022).
	7.Continue with TPN		**7**. TPN provides essential nutrients to patients who cannot meet their nutritional needs through oral or enteral feeding. It supports hydration, electrolyte balance, and adequate calorie intake, promoting overall health and healing (Nix & Bryant, 2022).
	8.Monitor blood sugar and treat per ordered correctional scale.		**8**.Hyperglycemia can disrupt various key elements of the healing process, making strict glucose management crucial for effective wound healing (Nix & Bryant, 2022).

References:

Beitz, J. M. (2022). Wound healing. In L. L. McNichol, C. R. Ratliff & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management.* (2nd ed., pp. 39-53). Wolters Kluwer.

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 Nurses Society core curriculum: Wound management.* (2nd ed., pp. 396-422). Wolters Kluwer.

Jaszarowski, K., & Murphree, R. W. (2022). Wound cleansing and dressing selection (2022). In L. L. McNichol, C. R. Ratliff & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management.* (2nd ed., pp. 157-171). Wolters Kluwer.

Mackey, D., & Watts, C. (2022). Therapeutic surfaces for Bed and chair. In L. L. McNichol, C. R. Ratliff & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management.* (2nd ed., pp. 425-444). Wolters Kluwer.

Thayer, D., Rozenboom, B. J., & LeBlanc K. (2022). Prevention and management of moisture-associated skin damage. Medical adhesive-related skin injury and skin tears. In L. L. McNichol, C. R. Ratliff & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management.* (2nd ed., pp.323-353). Wolters Kluwer.

WOC Complex Plan of Care

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: _____