WOC Complex Plan of Care

Name: _____Jasmine J. Lee_____ Patient Encounter Date: _____

Preceptor for Patient Encounter: ___MaldonadosVillalobos_____

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
Follow up visit for wound vac change ← *remember this is a brand name.* S.C. 31y.o. M Pmhx: Homeless, HIV, DM2, Protein calorie malnutrition, medical noncompliance, Hidradenitis Suppurativa. S/p debridement to bilateral buttocks and perineum on 11/19/2024 Patient came to ED 12/10 with complaints of worsening pain, swelling, and drainage to buttocks wound. Patient denies fever and chills. CT A/P reveals new tissue swelling, subcutaneous edema and increased skin thickening involving the left thigh and gluteal regions with extensive subcutaneous gas concerning for necrotizing soft tissue infection. Gen. Surgery consulted for necrotizing fasciitis- Surgery not concerned for Necrotizing fasciitis, signed off. Wound MD consulted recommended wound care follow up at wound clinic and possible SNF placement. Infectious disease consulted who then reconsulted surgery. Labs upon admission: Lactic acid 3.4, CRP 29.74, WBC 20.6 Albumin 1.4, Max temp 101.3. Blood cultures collected. Empiric antibiotics started. Sepsis protocol started. 12/13- Incision to Left buttock 24x20cm, right buttock 30x18cm, and left hip 20x12cm, per surgery. Orders given for Dakins 0.125% wet to dry performed daily by nursing. 12/15- Creation of diverting loop colostomy in order to maintain a clean environment during wound healing. 12/ 16- Ostomy teaching started by wound care nursing. Patient was instructed to help pouch emptying, and WOCN nurse continues with pouch changing.	**Upon admission Abnormal labs** **CRP 29.74** **Lactate 3.4 →1.3** **Blood culture No growth** CT A/P reveals new tissue swelling, subcutaneous edema and increased skin thickening involving the left thigh and gluteal regions with extensive subcutaneous gas concerning for necrotizing soft tissue infection. **Labs after 12/30 vac change (12/31/24)** **RBC 2.43** **HGB 6.2** **HCT 21.1** **Na 135** **Ca 7.8** **Mag 1.5**

12/26- Wound vac ordered and started by CWOCN, ostomy appliance also changed. 12/30- Prior to arriving on the floor, the nurse was asked to pre-medicate the patient, who was given Roxicodone and Ativan. The nurse was also asked to turn off the wound vac approximately one hour before the WOC nurse and CWOCN arrival. Once in the room, this nurse reintroduced herself to the patient and explained what was going to happen. The patient is in agreeance with the plan and is already lying prone in bed. The patient asked about the level of pain that might occur during the dressing change, and he was made aware that there would be some discomfort, the patient then asked for as-needed pain meds prior to the start of the removal. Before removing the drape and foam, the line to the trackpad was cut with scissors, and saline was inserted through the line to moisten the foam further and facilitate easier removal. Adhesive removal spray was utilized to release the draping and to help remove the Eakin that was used to protect the peri-wound prior to draping. Removal of the foam and drape was very difficult and required that the patient be administered intravenous pain medications three separate times and benzodiazepine administered once as well. Multiple messages were sent to the surgical MD requesting medications for better pain management. The patient had a heart rate of 130's-180's throughout the dressing change. During the early stages of removal, the patient expressed significant discomfort, and the WOC nurse stopped removal to allow the patient to compose himself in order to continue. Normal saline was continuously applied to the foam to aid with removal. Although the patient complained of pain, with the gloved hand, he helped in the removal of some of the foam dressing in order to have some control of the amount of pain felt. The patient understood the need for the wound vac and was willing to undergo the uncomfortable process. Once the foam dressing was removed after about 2.5 hours of attempting to remove it, the full wound bed was visualized. The wound bed is pink and moist, and no signs of non-viable tissue were noted. Total wound measurement 57.5x 49.5x 0.8cm. Some undermining was noted to the right ischial edge of the wound, measuring 0.4 cm at 6 o'clock; edges are slightly rolled along the transverse incision line across the lower lumbar. Serosanguinous drainage was noted throughout. Excess hair around the perineal was shaved in order to help with adherence to transparent dressing and to aid in less painful removal. The last dose of pain medication was given, and the patient was given time to rest before reapplying foam and drape. Cavilon no sting spray was applied to the peri wound and allowed to dry. An Eakin block was cut into strips, and the strips were applied along the edges of the wound to protect the skin. A contact layer was applied to the wound bed to help with removal with the following change, and then a black foam layer was placed and covered with a transparent dressing. Shallow cuts were made to the transparent dressing in order to make a hole that is a quarter in size; this will facilitate proper suction without any blockage. Tubing was connected. Ensured the ordered vac setting was inputted on the machine. Once started, suction was noted to the dressing, and no air leak was noted. During this change the patient asked questions regarding future vac dressing changes. Patient was made aware by MD that a graft would be needed in the future and the patient inquired to CWON about where graft would be coming from. Recent MD note suggested the need to add vitamin D and zinc supplements for the patient, as well as to change their diet. Patient placed on an HS diet consisting of No beef, no dairy, and no yeast, high protein, high calorie diet. Juven was also added to diet. Patient was previously on a low air loss mattress and was ordered an Envella air fluidized bed due to the patient spending a lot of time on his right hip due to the wounds on his left hip and bilateral buttocks. The	

bed allows for cooler microclimate and helps to relieve pressure off the boney prominences.	

Assessment	Plan/Interventions/Alternatives	Evaluation	Rationale
Skin alteration due to excision of HS affected area	Nursing to assess pump & dressing to ensure functioning. Pump should be ON, power cable plugged into power outlet, dressing clean dry & intact and compressed. Floor Nursing staff to troubleshoot alarms 1. Check tubing for kinks, may need to replace canister or track pad if blockage persists 2. Keep machine plugged in when not ambulating 3. Change cannister weekly and when full 4. If air leak noted. Patch with extra drape tape or tegaderm 5. Check trackpad to ensure it is in place. Can replace if it is pulled off. VAC therapy should not be interrupted for >2 hours cumulatively per 24-hour period of time. If unable to troubleshoot VAC and WMST is unavailable. Please remove dressing and apply moist to dry dressing with 0.9% normal saline every 12 hours and when soiled. ← *this is the same concept as a wet to dry dressing. We don't want the dressing to dry out in the wound, as it will be a traumatic removal with non-selective debridement. A temporary wet dressing, or a primary layer to treat the wound bed is indicated here. Make sure you are documenting this correctly as well, as the use of a wet-to-dry dressing here is not evidence based and could be subject to poor*	Patient is receiving uninterrupted therapy, promoting wound healing.	the use of a negative pressure wound therapy helps to assist in wound healing by increasing blood flow to the area therapy is being used as well as reducing inflammation and providing some debridement. Its use with this patient not only helped with increased speed of healing but also help in decreasing risk of infection by aid the body to rebuild the tissue that are affected quicker. (Netsch, 2022). With loss of suction, there is no removal of the exudate from the wound leading to increased risk of infection to the wound (Netsch, 2022).
Patient at risk for pain due to dressing changes		Contacted the physician for medications that would be given for wound care only. Orders also received for Ativan IV to be giving prior to vac dressing exchange *Make sure to include the patient in these evaluations. Use a validated scale to quantify pain and illustrate pain management is successful.*	Pain control during wound dressing changes should be an ongoing assessment. Insufficient pain control during dressing changes can lead to inadequate care such as incomplete cleansing or packing. This will lead to an increased chance of infection leading to a delay in wound healing Admassie et al, 2022).

	interpretation should documentation come under review. Physician contacted in order to recommend additional pain medication for patient during NWPT therapy dressing changes - *Be directive with these statements. What is your instruction?*		Poor pain control during dressing changes leads to poor wound healing due to the stress felt related to the dressing change. This activates the patient fight or flight response as well as vasoconstriction and the production of cortisol and catecholamines (Ermer-Seltun et al, 2020). Intense pain experienced during a wound dressing change will lead to greater chance of noncompliance and may prolonging the course of treatment. Infection of the wound could be possible if clinician is unable to properly clean the wound bed prior to foam replacement or leaves the clinician from being able to properly place the wound onto the wound (Admassie et al, 2022). Complications with the use of negative pressure wound therapy such as signification pain, difficult removal of foam, or retention of foam in the wound would indicate the need for a nonadherent contact layer (Netsch, 2022). Administration of pain medication prior to wound care and allowed the appropriate time for positive results helps with compliance with wound dressing changes. *Consider nutritional ramifications here too.* The application of a nonadherent dressing known as a Contact layer aids in maintaining a less traumatic dressing

Patient at risk for impaired skin integrity to due to lack of ability to make large movements Braden score: 19 Sensory perception : 4 Moisture : 3 Activity : 2 Mobility: 3 Nutriton:4 Friction and shear: 3	Air fluidized bed ordered due to having a very limited amount of area in which he lay due to the colostomy and the large posterior wound. Plan is for NWPT therapy dressing changes that do not cause the patient pain while preparing the wound for possible skin graft in the future. Recommendations to MD for intravenous pain medications and anxiety for NWPT therapy dressing changes. *How often is this dressing changed? Make sure this is aligned with professional assessment and manufacturer guidelines.* A light dusting of Convatec stomahesive powder applied to wound edges and sealed with 3M Cavilon no sting barrier film spray. No sting barrier film spray also applied to lateral right leg in order to protect the skin on which the bridge will be placed. 3M vac drape cut into strips and placed from the edge of the wound to the lateral right leg for bridging. ← *be directive. Don't state what you did in a plan, state what is needed to be done.* Once dried, convatec eakin cohesive block, cut into strips. These strips was then applied to the wound edges.	The patient's skin is free of pressure injuries	removal. A contact layer such as Mepitel is a mesh like structure which allows any exudate to pass through into the wound vac system. It maintains a moisture balance and protects the wound bed. (R. B. Turnbull Jr. MD WOC Nursing education Program, 2022*). <- if the wound is very shallow, decrease NPWT wear time, or find an alternative dressing type.* The use of the air fluidized bed will help to reduce the risk of pressure injury due to skin break down. The bed will help to maintain a cool and dry microclimate by providing air flow to the skin as well as to help relieve any pressure to the patients' boney prominences with pressure redistribution by providing a surface that moves like liquid (Mackey et al, 2022). Although the patient had a low risk of developing a pressure injury, the patients is very limited to how he is able to move in bed as he has an extensive open wound to lower back and buttock and a new colostomy in place. The use of the stomahesive powder and barrier film helps to create an extra protective layer on the skin. The use of the eakin strips along the wound, helps to maintain a good seal on the wound vac dressing as well as to further protect the skin from damage from

	Mepitel was then place throughout the wound as contact layer to help aid in dressing removal. ← *be directive. Don't state what you did in a plan, state what is needed to be done.* Once in place, Extra-large granulofoam dressing then cut to fit the wound bed and applied over contact layer. Black foam also applied along the draping placed to the right leg. Strips of 3M vac drape was cut into strips in order to make covering the wound more manageable and placed onto black foam. Quarter sized hole made onto the vac drape at right lateral leg in order to accommodate the opening of the track pad, and track pad placed 3M™ V.A.C.® Ulta Therapy Unit used for wound vac therapy. Machine was turned on and allowed to boot up. Canister replaced with 100ml canister. Tubing from machine and track pad connected and all clamps are open. Machine set to ordered pressure and therapy started. ← *be directive. Don't state what you did in a plan, state what is needed to be done. Where should tubing be anchored?* 1/2/25 wound vac performed. Changed with less time. Patient experienced less pain with this vac change.	Minimal pain experienced during NPWT dressing change. Wound bed almost at skin level. Reevaluate the need for continued NPWT.	black foam that may have been cut a little larger than the wound bed. The use of eakin cohesive although is primarily made for ostomy and wound manager use, the use of the eakin is able to fill in the gaps in harder to vac places, such as this person perianal area, creating an even plane to place wound vac drape onto.

	1/6/2 Last vac change performed. Recommended to MD that area should be evaluated for possible graft. 1/9/2024 graft performed. Grafts taken from bilateral posterior thighs Patient would benefit from a consult with a dietician in order to maintain a diet that is non-inflammatory, such as no red meat and no dairy. The need to change his diet can help with reoccurrence to HS in other locations of the body. *Be directive here.* pt/ot?	*What will be observed with these consults?*	*Why are other services indicated here?*

References:

Admassie, B. M., Ferede, Y. A., Tegegne, B. A., Lema, G. F. & Admass, B. A. (2022). Wound-related procedural pain management in a resource limited setting: Systemic review. *International Journal of Surgery Open*. 47. https://doi.org/10.1016/j.ijso.2022.100549 (Netsch, 2022).

Ermer-Seltun, J. M., Rolstad, B. S. (2022). General principals of topical therapy. In L. L. McNichol, C. R. Ratliff & S. S. Yates (Eds.), *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 136-152). 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. 214-233). Wolters Kluwer.

Netsch, D. (2022). Refractory wounds: assessment and 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. 214-233). Wolters Kluwer.

R. B. Turnbull Jr. MD WOC Nursing education Program. (2022) [Lecture notes on topical therapies part 2].

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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	*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	*8*	*Be specific.*
	Propose alternative products. Include generic & brand names	4	*2*	*See my comment. Make sure you are following EBP*
Evaluation	Identify plan of care evaluation parameters that demonstrate the desired outcomes	6	*4*	*Present for most points*
Rationale	Explain the rationale for identified interventions	6	*5*	*Make sure all actions are justified. Pain management is important, but consider other holistic influences on healing – nutrition, mobility, etc.*
Scholarly work	Rationales referenced & cited according to APA formatting guidelines	1	*1*	
	Proper grammar & punctuation used	1	*1*	
	References: See the course syllabus for specific requirements on references for all assignments	1	*1*	
	Total Points 80 % or higher is required to pass. Minimum scores: Ostomy: 36/45 Wound and Continence: 40/50		*40/50 (-1 resub)*	

Additional comments:

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Hi Jasmine – see my comments throughout. You have reached the 80% threshold on this assignment and no further work is needed on it. Make sure to consider my comments on this revised assignment for future work and studying/practice. Be as specific as possible when providing instruction/order. State exactly what you need, how often you need it, and when rationalizing, why. Reach out with any further questions! -Mike

Reviewed by: ___Mike Klements received revised 2/25/25_____ Date: __2/26/25_____