# CLINICAL PRECEPTOR RESOURCE MANUAL


**Wound, Ostomy, and Continence Nursing Education Program (WOCNEP)**
**Rutgers University**
**School of Nursing-Camden**
**311 N. 5th Street**
**Camden, NJ 08102**



**Updated 9/2016**

# CLINICAL PRECEPTOR RESOURCE MANUAL

This manual is designed to provide you with critical information that will facilitate your understanding of the Rutgers University School of Nursing-Camden WOCNEP clinical practicum. Specific steps are highlighted to help you through the selection and application process. The manual is pertinent for the on-site and future distance learning formats.

The forms that are required to be submitted during the practicum are included in this guide. Included at the end of the manual are the expanded content outlines for each of the two required courses as well as the preceptor evaluation form that is to be completed by the student.

Additional assistance is available to you by calling Rutgers University School of Nursing-Camden Dr. Janice Beitz at: 856-225-6791 (janice.beitz@camden.rutgers.edu) or WOCNEP Administrative Assistant, Tom Porvaznik, at: 856-225-2318 (porvazta@camden.rutgers.edu).

# CLINICAL PRECEPTOR RESOURCE MANUAL

I. Clinical Preceptor Credentials (WOCN Accreditation Committee Criteria – 2015)

A. Baccalaureate degree or above in nursing or registered nurse with baccalaureate degree in a discipline other than Nursing. (Competencies in Health Assessment, Community Health Nursing, Pharmacology, Leadership and Management and Research and Statistics must be documented.)

B. Current board certification in CWOCN Tri-specialty Nursing or specialty certification in the nursing specialty in which they teach from a nursing specialty organization or national nursing credentialing center.

C. One year of full-time clinical experience after graduating from an accredited WOC Nursing education program and certification.

D. Documented caseload: data to be submitted to Rutgers University School of Nursing-Camden WOCNEP.

E. Previous teaching experience as a clinical preceptor or participation in a clinical preceptor workshop or structured learning program including principles of adult learning, critical teaching strategies and clinical evaluation methodology or clinical nursing educator experience.

1a. Alternate Clinical Provider

In order to meet a program's or students objectives in a situation where a nursing certified preceptor is not available to teach a specific skill (e.g., urodynamic assessment or sharp debridement), clinical time with an Alternate Clinical Provider may be arranged. The Program Director will assume responsibility for assuring that the clinical objectives are clearly defined and congruent with the selected learning experience. The Alternate Clinical Provider will be responsible for providing written evidence of clinical competency from their facility or manager. The Program Director will be responsible for maintaining the credentials of the Alternate Clinical Provider. Please note: An Alternate Clinical Provider is defined as any licensed health care provider other than a certified specialty nurse. This may include and is not limited to physicians, advanced practice nurses, physical therapists (for components of wound care such as debridement or pulse lavage if there is no CWOCN or CWCN in the area that does this), urological technicians, RNs with ADN preparation, or LPNs (for urodynamics and electrical stimulation for continence if there is no CWOCN or CCCN in the area that does this).

II. Preceptor Application Packet

Request forms for a clinical preceptor/clinical experience will be distributed in class (on-site students) or sent electronically as an e-mail attachment. They will also be posted and available in digital platform courses. The request forms can be returned personally by students or mailed to Dr. Janice Beitz. It is crucial to have correct contact information regarding the person handling organizational contracts. Once request forms are submitted preceptor application packets and agency contracts will be mailed directly.

III. Application Process for Preceptors

A. Complete application and submit to Dr. Janice Beitz, PhD, RN, CS, CWOCN, CRNP, MAPWCA, ANEF, FAAN, Program Director at Rutgers University School of Nursing-Camden WOCNEP. Include all of following data with the application form:

1. Application Form
2. College transcript (if you received your WOC Nursing education prior to 1985).
3. Patient statistics for prior twelve months. A statistics form is included in this manual. (Appendix A)
4. A copy of board certification diploma. (CWOCN, etc., if appropriate)
5. A copy of current nursing license in your state of clinical practice
6. Resume or curriculum vitae
7. Proof of professional liability insurance (or proof of coverage by your employer)
8. Current CPR certification (**if required by employing agency**)

B. From time to time you may be asked to furnish updated documents as those on file expire, i.e., nursing license, liability insurance policy, etc. We would appreciate your prompt cooperation in sending them to our office.

**INPORTANT: ALL REQUIRED PRECEPTOR AND STUDENT DOCUMENTATION AND A SIGNED CONTRACT MUST BE ON FILE AT RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP BEFORE THE STUDENT MAY BEGIN THE CLINICAL PRACTICUM.**

IV. Required Learning Activities

A. The Program's hour requirement for the clinical practicum is 160 minimum hours. Minimum requirements in each practice area are as follows:

| | |
|---|---|
| **Wound Care/Management** | **40 - Hours** |
| **Ostomy/Stoma Management** | **40 - Hours** |
| **Continence/Management** | **40 - Hours** |
| **Professional Practice/Role Components/Program Director's Discretion** | **40 - Hours** |

**Program Director's determined hours are allotted according to students' individualized learning needs. Please note that students may elect to complete additional clinical hours above the 160 hours.**

B. The student will have experiences in more than one practice setting (Acute Care, Home Care, Extended Care, Outpatient Care, etc.). Acute care is the preferred primary site due to the number and variety of patients. Additional practice settings may be selected. Ideally, the preceptor's average daily census supports clinical learning experiences at the level of 6 patients or more per day.

C. The student will have sufficient clinical experience in the areas of WOC scope of practice to achieve WOCN Competencies as defined by the WOCN.

V. The student may spend a limited amount of time with a non-credentialed preceptor, once the WOCN 160-hour requirement is met. Observational experiences with other health care clinicians are optional and are not counted as part of the required 160 hours of clinical experience.

VI. Clinical Competencies identified by WOCN are included with this guide.

VII. Legal Issues:

A. An entry requirement to the Rutgers University School of Nursing-Camden WOCNEP is professional liability insurance in the amount of $1,000,000 per claim and $6,000,000 per aggregate.

B. A contract that has been developed by Rutgers University School of Nursing-Camden WOCNEP legal advisors will be sent to your agency's representative. Elements of the contract often need to be negotiated with your legal department. Please forward the contract to the appropriate department as soon as possible. Contract negotiations can take months to finalize.

VIII. Documentation

A. The student is required to submit clinical logs for the clinical practicum. A sample form is included in this guide. The student must submit clinical logs at 80 and 160 hours.

B. The clinical preceptor is required to submit anecdotal notes at 80 hours (half-way point). The purpose of the anecdotal note is to communicate the student's progress to the Program Director. A sample form is included in this guide.

C. A form is provided for the final evaluation of the student at the completion of the clinical practicum. The evaluation form must be submitted to the Program Director within ten (10) days of completing the clinical practicum. **The student's graduation from the program cannot be processed until all documentation is received. The form is included in this guide.**

D. Upon completion of the clinical practicum, the student will be required to successfully complete the comprehensive final examination (if not completed already) with a grade of at least 80% and submit evidence of completing the self-assessment examination (SAE) from the Wound, Ostomy, Continence Certification Board (available at www.wocncb.org).

E. Upon completion of the clinical practicum, the student will submit a completed evaluation form of the clinical preceptor (Appendix G).The student must complete the required clinical practicum hours and all testing within **nine months** of completing WOC Nursing II (See NUR 552 Syllabus).

Any questions regarding the preceptor experience will be answered by Dr. Janice Beitz, PhD, RN, CS, CNOR, CWOCN, CRNP, MAPWCA, ANEF, FAAN, Program Director. Please feel free to call the School of Nursing office at 856-225-2318 or 856-225-6791. Office hours are 8:00 AM – 4:30 PM, Monday to Friday, Eastern Standard Time.

IX. Primary & Secondary Preceptors

A. The Student may wish to spend time with more than one preceptor. We require that one preceptor be designated as a primary preceptor; however, it is often necessary to arrange to have secondary preceptors. We recognize that not all ET (WOC) Nurses' practices include sufficient numbers of wound, ostomy and incontinence patients to provide an adequate learning experience. When more than one preceptor is used, each preceptor must complete the application/contract process and complete or add to the student's final evaluation form.

B. Please note the previous description of alternate clinical provider and associated responsibilities. Alternate clinical providers can be used for experiences in selected learning activities (e.g., debridement, pulsed lavage, urodynamics, electrical stimulation, etc.) if there is no CWOCN or CCCN or CWCN in the area. The alternate clinical provider is responsible to complete the application contract process and complete or add to student's evaluation documentation with written evidence of clinical competency.

X. A clinical preceptor may work with only 2 clinical students at a time. Ideally, clinical preceptorship experiences should be 1:1 ratio.

# RESPONSIBILITIES
# OF
# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP

1. Provide assistance to student in selecting a preceptor upon request.

2. Send application, clinical documentation forms, and contract to preceptor and/or appropriate agency personnel.

3. Notify preceptor of acceptance.

4. Notify student that a signed contract has been received.

5. Return copy of signed contract to preceptor.

6. Notify student in writing of permission to begin clinical practicum. Notification specifies student's and preceptor's documentation is complete and agency contract signed.

# RESPONSIBILITIES OF THE STUDENT

1. Select and obtain an appropriately credentialed preceptor, as per WOCN accreditation criteria.

2. Notify Rutgers University School of Nursing-Camden WOCNEP of selection of preceptor in advance of program start date or during first months of academic year (September, October) to allow time for completion of preceptor application and contract signing. Students are urged to start this process as early as possible as contract processes can take up to twelve months to complete. Students will not be permitted to enroll in WOC Nursing II if they have not applied for a preceptor during the fall semester.

3. Communicate with preceptor regarding clinical orientation and institutional policies.

4. Notify Program Director immediately if issues/concerns occur.

5. Submit clinical logs at 80 hours and 160 hours of practicum.

6. Submit clinical preceptor evaluation form (Appendix G) and the clinical competency checklist (Appendix B) (included in this guide) within ten (10) days of practicum completion.

7. Students must complete the required clinical practicum hours and all required testing **within nine months** of completing WOC Nursing II. (See NUR 552 syllabus). Students failing to comply may be required to repeat WOC Nursing I.

# RESPONSIBILITIES
# OF THE CLINICAL PRECEPTOR

**BEFORE THE CLINICAL PRACTICUM BEGINS:**

1. Provide the following information to student so that application, contract and clinical criteria can be mailed to you:

   Full name and credentials
   Name of institution/agency
   Mailing address of institution/agency
   Telephone number and Email Address
   Name and full contact information for person(s) processing agency contracts.

2. Submit completed preceptor application and required documentation to Rutgers University School of Nursing-Camden WOCNEP in a timely manner. Please submit a complete packet to the WOCNEP. Incomplete packages cannot be processed.

3. Obtain a letter of support from your administration and submit to Rutgers University School of Nursing-Camden WOCNEP with application packet.

4. Check that the contract has been received in the appropriate department for signature; **track progress of contract**!! Check with WOCNEP Administrative Assistant at: 856-225-2318.

5. Negotiate fee (if any) for service with student. (Rutgers University School of Nursing-Camden WOCNEP is not involved in this process).

6. Communicate information to student regarding orientation and institutional policies at clinical affiliation.

**DURING CLINICAL PRACTICUM:**

1. Provide clinical supervision for student's learning experience.

2. Communicate with student on a daily basis regarding learning progress.

3. Submit to Rutgers University School of Nursing-Camden WOCNEP anecdotal notes at 80 hours and final evaluation at 160 hours.

4. Contact Program Director immediately if problems or concerns occur.

5. Work with no more than two students at a time in a clinical practicum experience.

**AFTER CLINICAL PRACTICUM:**

1. Submit to Rutgers University School of Nursing-Camden WOCNEP the following forms:

   A) Appendix B (Clinical Experience)
   B) Appendix F (Evaluation of Clinical Practicum)
   C) Clinical Competencies Form (8-page form)

# JOB DESCRIPTION

**POSITION TITLE:** **Clinical Preceptor (Faculty)**

**REPORTS TO:** **Program Director**

DESCRIPTION

The clinical preceptor collaborates with the Program Director and Co-Director in providing a learning experience for the WOC nurse in accordance with the WOCN Accreditation Committee and Rutgers University School of Nursing-Camden WOCNEP standards.

POSITION RESPONSIBILITIES:

1. Select, provide and supervise clinical learning experiences for students related to wound care, abdominal stoma management, incontinence, and professional practice.

2. Collaborate with Program Director and students in the planning, implementation and evaluation of the clinical practicum.

3. Provide students with an orientation to the clinical facilities' policies, procedures, and standards of WOC Nursing practice.

4. Provide the opportunity at regular intervals for the student to express points of view and share knowledge and experience related to the clinical practicum.

5. Communicate openly with the students, faculty and Rutgers University School of Nursing-Camden WOCNEP personnel regarding student progress and related issues.

6. Complete anecdotal records and evaluation forms within contractual designated timelines.

7. Maintain and support the educational standards set forth by WOCN Society and Rutgers University School of Nursing-Camden WOCNEP.

Job Description: Clinical Faculty

EDUCATION & EXPERIENCE:

1. MSN, BSN or Bachelor's Degree in another field with documentation of equivalent competency in: health assessment, pharmacology, community health nursing, leadership and management, and research and statistics.

2. Certification: WOCNEP graduate - CWOCN required; or national nursing certification in specialty in which they teach.

3. Experience: At least 1 year full time after WOCNEP graduation. CWOCN practice, including wound, ostomy and/or continence management.

4. Completion of a preceptor workshop to include principles of adult learning, clinical teaching strategies, and clinical evaluation methodology; or evidence of prior preceptor experience.

DATE: _____

WRITTEN BY: Janice Beitz PhD, RN, CS, CNOR, CWOCN, CRNP, MAPWCA, ANEF, FAAN

APPROVED BY: Curriculum Committee

_____ _____

Rutgers University School of Nursing WOCNEP Program Director

Date

**APPENDIX A**

**RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP PRECEPTOR APPLICATION**

**Patient Census/Clinical Statistics for Most Current Year (Previous 12 Months)**

**Year____**

**(In each column identify the number of patients seen)**

| **Clinical Content** | **Acute Care** | **Outpatient Care** | **Home Health** | **ECF/SNF** | **Other Describe** |
|---|---|---|---|---|---|
| Colostomy | | | | | |
| Ileostomy | | | | | |
| Urostomy | | | | | |
| Continent Ileostomy (Kock, J-Pouch, Pelvic Pouch) | | | | | |
| Continent Urostomy (Kock, Indiana, Neobladder) | | | | | |
| Surgical Wounds | | | | | |
| Fistulas and Drains | | | | | |
| Pressure Ulcers | | | | | |
| Venous Stasis Ulcers | | | | | |
| Neuropathic Ulcers or Foot Care Clinic | | | | | |
| Skin Irritation and/or Infections | | | | | |
| Urinary Incontinence/ Bladder Programs | | | | | |
| Fecal Incontinence/Bowel Programs | | | | | |
| Other areas not mentioned above | | | | | |

- Please give an **estimate** of the number of cases in each category for which you were consulted in the specified year.

_____

Preceptor Signature and Credentials

_____

Institution(s)

_____

Date

Average Daily Census of WOC Patients: _____

**APPENDIX B**

**CLINICAL EXPERIENCE**

**Instructions:** Listed below are clinical experiences required for graduation from the Rutgers University School of Nursing-Camden WOCNEP. Please place the preceptor's initials in the blank provided. Return this form at end of clinical preceptorship.

**Initials**

**Ostomies and Continent Diversions**

1. Stoma site selection (average and special considerations patients) _____
2. Specimen collection (Catheterization of urinary diversion) _____
3. Irrigation/lavage procedures (colostomy, ileostomy) _____
4. Appropriate product selection for pouching systems _____
5. Pouching with disposable and reusable products _____
6. Intubation _____
    a) continent diversions (urinary & fecal) _____
    b) feeding enterostomies _____
7. Stomal assessment and management _____
8. Management of stomal/peristomal complications _____
9. Skin care management _____
10. Stabilization of percutaneous tubes _____
11. Teaching and counseling persons with above needs _____

**Acute and Chronic Wounds, Fistulas**

1. Skin risk assessment processes and prevention strategies _____
2. Wound assessment & staging (chronic and acute) _____
3. Stabilization tubes and drains _____
4. Product selection and utilization - prevention/management _____
5. Culture techniques _____
6. Wound cleansing techniques _____
7. Accurate identification of debridement techniques (Students do not perform sharp debridement) _____
8. Wound packing _____
9. Periwound management _____
10. Compression therapy - products and processes _____
11. Ankle/brachial index and vascular assessment _____
12. Fistula management techniques _____
13. Accurate identification of causative/contributing skin lesions _____
14. Selection pressure redistribution support surfaces
15. Application of negative pressure wound therapy (e.g., NPWT) _____
16. Teaching and counseling persons with above needs _____

**Incontinence**

1. Focused physical exam _____
   a) abdominal _____
   b) skin _____
   c) rectal & bulbocavernosal reflex _____
2. Perform simple urodynamics (PVR, observe voided stream, etc) _____
3. Pelvic muscle exercises _____
4. Bowel & bladder programs (scheduled voiding, prompted voiding, voiding diary, bladder retraining) _____
5. CIC (clean intermittent catheterization) _____
6. Biofeedback _____
7. Pessary management _____
8. Electrical stimulation _____
9. Product selection and utilization – protection/containment _____
10. Management skin breakdown _____
11. Teaching and counseling the person who is incontinent. _____

**Please note: These can be accomplished in a laboratory - type practice setting with the clinical preceptor as well as in direct patient care situations.**

**Appendix C**

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOUND, OSTOMY AND CONTINENCE NURSING EDUCATION PROGRAM (WOCNEP)

# CLINICAL LOG GUIDELINES

Each WOC Nursing student is required to maintain a clinical log. Entries may be made daily or weekly. However, daily entry is recommended. Information to be included in the log will focus on specific clinical experiences and an evaluation of the nursing care provided to the client (s). Impressions and feelings relating to the clinical experience may also be a focus for the clinical log. Log entries should be submitted to the preceptor and Program Director upon completion of 80 and 160 hours.

The purpose of the log is to promote communication and relationship skills. It will also provide direction for dialogue among/between the preceptor and program director. Focus on the patients that provided optimal learning experiences.

Please use the form that follows.

**RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP**
**CLINICAL LOG DOCUMENTATION FORM**

Student Name: _____ Clinical Preceptor Name: _____ Date: _____

Clinical Site: _____ 80 Hours/160 Hours
(Circle One)

Use this form to document patient visits in each content area that demonstrate critical decision-making and skills acquisition. The right hand column allows the student to self-identify which aspects of WOC nursing have been enacted: W (Wound) O (Ostomy) C (Continence) R (Role-teaching, administration, research, consultation, leadership)

**RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN**
**PATIENT LOG**

| Date | Patient Initials (Age/Sex) | Primary Diagnoses | Pertinent History | Physical Exam Results | Management Issues/Skills Acquired | Patient Education Issues | Wound, Ostomy, Continence, Role (WOCR) Record "W", "O", "C", "R" |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

Single most interesting, educational event from this week's experience:

_____

Educational goals for next week:

_____

What clinical practicum competencies did you meet this week?

_____

What clinical practicum competencies do you still need to meet?

_____

**RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP**
**CLINICAL LOG DOCUMENTATION FORM**

Student Name: _____ Clinical Preceptor Name: _____ Date: _____

Clinical Site: _____ 80 Hours/160 Hours
(Circle One)

Use this form to document patient visits in each content area that demonstrate critical decision-making and skills acquisition. The right hand column allows the student to self-identify which aspects of WOC nursing have been enacted: W (Wound) O (Ostomy) C (Continence) R (Role-teaching, administration, research, consultation, leadership)

**RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN**
**PATIENT LOG**

| Date | Patient Initials (Age/Sex) | Primary Diagnoses | Pertinent History | Physical Exam Results | Management Issues/Skills Acquired | Patient Education Issues | Wound, Ostomy, Continence, Role (WOCR) Record "W", "O", "C", "R" |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

Single most interesting, educational event from this week's experience:

_____

Educational goals for next week:

_____

What clinical practicum competencies did you meet this week?

_____

What clinical practicum competencies do you still need to meet?

_____

**Appendix D**

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOUND, OSTOMY, AND CONTINENCE NURSING EDUCATION PROGRAM

# ANECDOTAL RECORD GUIDELINES

Clinical preceptors are required to submit an anecdotal report to the Rutgers University School of Nursing-Camden Wound, Ostomy, and Continence Nursing Education Program Director upon completion of 80 hours of the clinical practicum. The purpose of these notes is to assess the attainment of clinical objectives and the development and adjustment of the WOC Nursing student. Anecdotal notes are required at the half way and completion phases to promote student learning and formative and summative evaluation.

This report should be based on data collected from observing the student in the clinical setting. Objectivity is critical to this process. Interpretations and judgments should be avoided.

The clinical preceptor is free to develop the format for the anecdotal record or may use the form included in this guide. Please submit the report as requested so that learning progression can be evaluated. Suggestions for alternative anecotal note format are welcomed.

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN
# WOUND, OSTOMY, AND CONTINENCE
# NURSING EDUCATION PROGRAM

## RECOMMENDATIONS FOR WRITING AN ANECDOTAL NOTE

1. Anecdotal notes are based on course objectives, evaluation tools and/or daily goals that are discussed with students.

2. Observations in anecdotal notes for a specific experience should be objective, factual and concise. They should be dated and timed. Describe incidents. Do not include opinions.

3. Description of the observation is separated from the interpretation and evaluation.

4. The description of the observation is objective; that is, it describes the events without labeling behaviors or interpreting them. State events as they occurred without emotional responses or personal feelings. Do not use the words "good" or "bad" without explanation. For example, "good WOC nursing care" is not an adequate statement; it must be accompanied by evidence such as assessment of the wound and the selection of appropriate treatment with supporting rationale.

5. The interpretation is objective in that the events are discussed by citing evidence and subjective by using such sources as prior student experiences and behaviors. Includes both behaviors that are typical or atypical (unusual).

6. Writing style is clear and concise.

7. Observe the student for a sufficient time to accurately and objectively assess the situation.

8. A summary of the notes should include a variety of behaviors that are both positive and negative examples.

9. Verify that student has met the minimum hour requirements for each content area in the four program areas.

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN
# WOUND, OSTOMY AND CONTINENCE
# NURSING EDUCATION PROGRAM

## ANECDOTAL RECORD FORM

Clinical Preceptor _____

Institution _____

Student _____

Date: _____

Description of Observed Student Behavior:

Preceptor Evaluation/Comments:

_____

Signature

## Appendix E

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP
# PROFESSIONAL PRACTICE: WOC NURSING I
# ROLE IMPLEMENTATION

## TOPICAL OUTLINE

**Objectives: Professional Practice Issues**

1. Describe key components of the WOC/specialty nurse role to include responsibilities for each of the following roles: Clinician/consultant; staff development; leadership/management; and role in research utilization and promotion of evidence-based practice.

2. Utilize current "best evidence" as basis for managing patient care and for program/protocol development.

3. Describe considerations and strategies for implementation of the specialty nurse role in her/his practice setting.

4. Identify legal and ethical issues that impact on the WOC/specialty nurse's role and practice.

5. Develop and implement effective staff development programs.

6. Develop procedures/processes for data collection and record keeping that support role justification and negotiation in her/his practice setting.

7. Demonstrate effective interpersonal and collaboration skills.

8. Utilize critical thinking skills to plan and implement evidence-based patient care and to identify indications for referral.

9. Demonstrate ability to critique current practice patterns and to advance practice utilizing principles of quality management and change theory.

10. Identify resources for assistance with role implementation and development or expansion of wound, ostomy, or continence-related programs.

Content Outline:

I. Specialty Practice Nursing: Essential Competencies and Responsibilities

   A. Legal/ethical issues and responsibilities
   B. Development and maintenance evidence-based practice
   C. Critical thinking: Definition, importance, strategies for building skill
   D. Development and management agency-wide programs in specialty areas(s)
   E. Interpersonal competence/collaborative skills (intradisciplinary and interdisciplinary)
   F. Literacy in digital communication
   G. Specialty practice versus advanced practice roles

II. History and Evolution of Wound, Ostomy, and/or Continence Nursing

III. Role Implementation Issues and Guidelines

A. Strategies for role implementation and program development

1. Importance agency-wide perspective/approach
   i. Analysis current practice in areas(s) of specialty
   ii. Development of action plan for optimizing care in area(s) of specialty
   iii. Utilization appropriate resources for development new programs (to include business plans when indicated) (marketing, budgeting, accounting, etc.)

2. Role negotiation and role justification
   i. Importance positive fiscal impact
      a) Relevant regulatory/reimbursement policies in various care settings
      b) Revenue generation vs. cost savings
   ii. Importance data collection and record keeping

3. Resources for establishing needed programs and evidence based care (facility-based and professional society-based) (e.g., Healthy People initiatives)

4. Role and program evaluation

5. Conflict management

B. Role components and key responsibilities

1. Clinician/consultant role
   i. Caregiver versus consultant role
   ii. Strategies for success in consultant role

2. Staff development/educator role
   i. Assessment learning needs
   ii. Development and implementation staff development programs
   iii. Development resource teams if indicated

3. Leadership/management issues
   i. Time management issues
   ii. Role in product evaluation and recommendations
   iii. Quality improvement initiatives (to include strategies such as root cause analysis and concurrent monitoring)
   iv. Role modeling and mentoring
   v. Responsibility for professional involvement (WOCN participation, specialty certification, continuing education)
   vi. Responsibility for own professional development

IV. Role in Research Utilization/Promotion Evidence-Based Practice

A. Importance of integrating research finding and best practice guidelines into care and recommendations

B. Strategies for advancing evidence-based practice
   1. Critical review of current literature and research reports
   2. Development evidence-based policies/procedures/protocols

C. Opportunities for contributing to research/advancement of specialty

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN
# WOUND, OSTOMY, AND CONTINENCE NURSING EDUCATION PROGRAM

# WOUND MANAGEMENT: NURSING INDIVIDUAL WITH POTENTIAL OR ACTUAL ALTERATIONS IN SKIN INTEGRITY (WOC NURSING I)

## TOPICAL OUTLINE

Objectives

1. Describe anatomy and physiology of skin and soft tissue, changes across the lifespan, and implications for maintenance of skin health/skin integrity.

2. Differentiate between acute and chronic wounds to include implications for management.

3. Describe physiology of partial-thickness and full-thickness wound healing and identify implications for nursing management.

4. Conduct a comprehensive assessment of the patient with compromised skin or soft tissue integrity to include history, physical examination, and appropriate diagnostic studies.

5. Use assessment data to determine the following:
   - Factors causing or contributing to the alteration in skin/soft tissue integrity;
   - Potential for healing and any systemic conditions that would interfere with healing;
   - Wound characteristics (to include phase of wound healing) and implications for wound management.

6. Develop an individualized plan of care based on assessment data and current evidence-based guidelines that addresses each of the following factors:
   - Correction or amelioration of etiologic factors;
   - Attention to systemic factors affecting repair process;
   - Evidence-based topical therapy;
   - Pain management;
   - Patient and caregiver education

7. Recommend or provide topical therapy based on best available evidence, to include:
   - Debridement of necrotic tissue when indicated;
   - Identification and management of wound-related infections;
   - Management of epibole and hypertrophic granulation tissue;
   - Selection of dressings to manage exudates and maintain moist wound surface.

8. Use data from serial wound assessments to identify wound deterioration or failure to progress.

9. Identify indications and guidelines for use of adjunctive therapies/referrals for further evaluation or medical-surgical intervention.

10. Demonstrate correct procedure for each of the following: Conservative Sharp Wound Debridement (CSWD); chemical cauterization; wound cleansing/dressing application; Non-invasive wound culture; application adjunctive therapies such as Negative Pressure Wound Therapy ((NPWT).

Content Outline

1. Anatomy and Physiology of Skin and Soft Tissue
   - Structures
   - Functions
   - Changes across the lifespan
   - Maintenance of skin/soft tissue integrity

2. Pathology of Impaired Skin/Tissue Integrity: Overview
   - Surgical
   - External mechanical factors (friction, shear, pressure, maceration)
   - Infectious processes (viral, fungal, bacterial)
   - Oncologic processes
   - Cytotoxic therapies (radiation and chemotherapy)
   - Immunologic processes
   - Vascular insufficiency
   - Chemical irritants
   - Thermal injury

3. Wound Healing Physiology
   - Partial-thickness wound healing
   - Full-thickness wound healing
   - Primary versus secondary versus tertiary repair
   - Factors affecting wound healing/implications for management
   - Acute versus chronic wounds

4. Assessment of Patient with Alteration in Skin/Tissue Integrity
   - History
     - Past medical/surgical history (comorbidities)
     - Smoking history, alcohol use, recreational drug use
     - Focused review of systems/factors relevant to wound healing
     - Social history, support system, economic concerns
     - Environmental and functional assessment
     - Onset and duration of wound (to include past management and response)
     - Impact of wound on quality of life (to include cultural issues)
     - Pain assessment (type, location, severity, exacerbating and relieving factors)
     - Prescription, over the counter, and herbal medications
   - Focused physical exam
     - Integumentary system
     - Nutritional status
     - Peripheral vascular system
     - Musculoskeletal and neurologic systems (focused assessment)
     - Wound characteristics (dimensions, tunneled or undermined areas, status of wound bed and wound edges, type of volume of exudates, status of surrounding tissue, etc.)

   - Laboratory studies and other diagnostic tests
     - Complete blood count
     - Albumin/prealbumin
     - Glucose/Hgb A1C
     - Culture reports
     - Vascular studies
     - Bone scans, magnetic resonance imaging

5. Synthesis of Data to Determine:
   - Etiologic factors for alteration in skin/tissue integrity
   - Systemic factors affecting repair/potential for healing
   - Wound characteristics/focus of topical therapy

6. Management of the Patient with Alteration in Skin/Tissue Integrity

- Development of appropriate goals (maintenance/comfort vs healing) in collaboration with patient/family
- Correction/reduction of etiologic factors (if possible)
- Systemic support measures (glycemic control, measures to promote perfusion, nutritional support, control of comorbidities, medication modifications)
- Topical therapy based on wound status, wound type, treatment goals, and best available evidence:
    - Indications, options, and guidelines for debridement of necrotic tissue (Autolytic, Biologic (Maggot), Chemical, Mechanical, Surgical, Conservative Sharp)
    - Guidelines for wound cleansing and cleansing solutions: Basic and Advanced Modalities
    - Identification and management of wound-related infections (osteomyelitis, cellulitis, critical colonization) to include appropriate technique for wound culture and appropriate use of topical antimicrobial agents/dressings—Guidelines for dressing selection (primary versus secondary dressings, absorptive versus hydrating dressings, importance of bacterial barrier in wounds exposed to urine or stool)
    - Dressing options for wounds with tunneling or undermining to include specific options for narrow tunnels
    - Management of closed wound edges (epibole)
    - Management of hypertrophic granulation tissue
- Importance of serial assessments
- Patient and family education (importance and key topics: Infection, Tobacco Cessation, Nutrition, Optimal Health Choices, Causative Factors)
- Pain management (premedication, topical and systemic analgesics, nonadherent dressings, breaks/"timeouts" when requested by patient, etc.)
- Specialty Need Populations: Bariatric and Pediatric

7. Surgical Management
    - Revascularization procedures (indications, preoperative/postoperative management)
    - Split thickness skin grafts (indications, preoperative/postoperative management)
    - Myocutaneous flaps (indications, preoperative/postoperative management)

8. Adjunctive Therapies: Indications and Guidelines for Use
    - Role of adjunctive therapies
    - Indications and guidelines for use of adjunctive therapies
        - Hyperbaric oxygen therapy
        - Exogenous growth therapy
        - Negative pressure wound therapy
        - Bioengineered skin equivalents
        - Electrical stimulation
        - Leech Therapy

9. Indications for Referral
    - Surgery
    - Pain Clinic
    - Orthotics
    - Dietitian
    - Social Services
    - Pastoral Care
    - Physical Therapy
    - Occupational Therapy
    - Mental Health Professional
    - Palliative/Hospice Care

10. Correct procedure for each of the following: conservative sharp debridement, Chemical cauterization, wound dressing/cleansing; non-invasive wound culture, NPWT application; Ankle-Brachial Index, Compression wraps/devices

**Wounds Caused by External Mechanical Factors: Prevention and Management**

Objectives:

1. Explain the pathology and clinical presentation of each of the following: Friction injuries; skin tears; maceration injuries.

2. Explain the role of each of the following in pressure ulcer development: Prolonged or intense pressure; shear force; tissue tolerance.

3. Discuss current theories of pressure ulcer pathogenesis to include both "top-down" and "bottom-up" theories.

4. Develop an evidence-based agency-wide program for pressure ulcer prevention that includes risk assessment on admission and at appropriate intervals thereafter, and prompt initiation of prevention measures for any patient found to be at risk.

5. Design a system to monitor incidence of pressure ulcers in a clinical agency.

6. Design a decision-making algorithm for appropriate use of offloading devices and therapeutic support surfaces (surfaces providing pressure redistribution, low volume air flow, low shear interface, alternating pressure, lateral rotation, and/or other therapeutic benefits).

7. Select/recommend appropriate pressure redistribution devices for bed, chair, and heels.

8. Utilize evidence-based risk assessment tool to accurately identify patients at risk for pressure ulcer development and to develop an individualized prevention program.

9. Correctly stage/categorize a pressure ulcer using the currently accepted staging system.

10. Identify limitations of the current staging system and implications for practice.

11. Describe the phenomenon known as "deep tissue injury," including implications for documentation and management.

12. Discuss issues related to pressure ulcer prevention among special populations, such as the bariatric patient, the patient undergoing a lengthy surgical procedure, the patient receiving vasopressors, and the terminally ill patient.

13. Incorporate current guidelines for pressure ulcer management into practice.

Content Outline:

1. General Issues Related to Impaired Skin/Tissue Integrity
   - Prevalence and incidence: Definitions; Methodological Issues in Clinical Settings, Interpretation of Data
   - Legal/ethical issues
   - Avoidable versus unavoidable pressure ulcers and Present on Admission (POA)
   - Economic Issues

2. Pathology and Presentation of Partial-Thickness Breakdown
   - Friction injuries
   - Skin tears: Classification Systems; Intrinsic/Extrinsic Factors, Prevention Strategies, Management
   - Maceration injuries

3. Pathology of Pressure Ulcer Development
   - Definition of term "pressure ulcer"
   - Characteristics of pressure injuries and pressure-shear injuries

- Role of prolonged/intense pressure, shear, and tissue tolerance in pressure ulcer development: Intrinsic and Extrinsic Factors
- Theories regarding pathogenesis: Ischemia caused by capillary occlusion, Reperfusion injury, Impaired lymphatic function; Prolonged deformation of tissue cells
- Clinical manifestations (persistent hyperemia, palpatory changes, and/or deep bruising under intact skin followed by full thickness ulcer formation)

4. Preventive Strategies
   - Risk assessment using research-based risk assessment tool/limitations of existing tools (e.g., Braden Scale)
   - Implementation prevention protocol for any patient found to be at risk

   a. Maintain skin health
   b. Optimize nutrition/hydration
   c. Pressure redistribution and offloading

   - Key elements effective prevention protocol
     - Turning and positioning guidelines
     - Appropriate use of therapeutic support surfaces (surfaces providing pressure redistribution, low volume air flow, low shear interface, alternating pressure, lateral rotation, air fluidized, and/or other therapeutic benefits)
     - Pressure redistribution: Immersion vs. Envelopment, Microclimate control (temperature and moisture), Friction and shear reduction
     - Appropriate use of positioning and offloading devices/heel elevation devices
     - Measures to reduce shear and friction
     - Measures to control maceration and moisture (management diaphoresis, incontinence management, etc.): MASD vs. IAD: Prevention and Management
     - Nutritional support
     - Routine skin inspection/skin care
     - Patient/caregiver education

5. Issues of Pressure Ulcer Prevention in Special Populations: Prolonged surgery, extended special procedures/ ER stays, Bariatric patients, Neonatal/pediatric patients, Palliative/End-of-Life patients, Patients receiving vasopressors
6. Creating an infrastructure for Pressure Ulcer Prevention
7. Documentation
8. Assessment Guidelines
   - Staging/classification
     - Currently accepted staging system
     - Limitations of staging/classification system
   - Narrative description
   - Documentation tools (PUSH, PSST (Bates-Jensen Wound Assessment (BWAT), etc.)

9. Surgical Approach to Pressure Ulcer Management: Surgical decision making/reconstructive ladder, categories of surgical tissue flaps, Preoperative considerations, Wound Bed preparation, Postoperative Management: Skin flaps and grafts, Managing complications
10. Management Principles
    - Correction etiologic factors
    - Systemic support measures (nutritional support, glucose control, etc.)
    - Topical therapy based on best available evidence (establishment clean wound bed, management of exudates, maintenance clean moist wound surface)
    - Indications and guidelines for use of adjunctive therapies
    - Indications for referral
    - Documentation
    - Patient/Caregiver Education

**Wounds Caused by Surgical Intervention**

Objective:

1. Identify intrinsic and extrinsic factors associated with surgical wound healing complications

Content Outline:

- Surgical Wound Closure
- Surgical Wound Assessment (Including healing ridge)
- Bariatric Considerations
- Topical Incision Care
- Impediments to surgical wound healing
  - Hematoma/Seroma
  - Surgical Site Infection (SSI)
  - Intrinsic/Extrinsic factors
  - CDC Criteria (Superficial, Deep, Organ SSI)

**Lower Extremity Ulcers: Differential Assessment and Management**

Objectives:

1. Compare and contrast arterial, venous, neuropathic, and mixed ulcers in terms of risk factors, pathology, clinical presentation, and management guidelines.

2. Describe critical parameters to be included in assessment of the individual with a lower extremity ulcer.

3. Demonstrate the procedure for ABI testing, TBI testing, TcPO2 testing, and sensory testing using Semmes-Weinstein monofilaments.

4. Interpret findings from ABI testing, TBI testing, TcPO2 testing, and sensory testing with Semmes-Weinstein monofilaments.

5. Use assessment data to determine causative and contributing factors for a lower extremity ulcer and to develop individualized management plans that are evidence-based

6. Identify indications, contraindications, options, and guidelines for implementation of the following: Therapeutic level static compression therapy, modified static compression therapy, and dynamic compression therapy.

7. Demonstrate correct technique for application of compression wraps.

8. Describe the impact of lifestyle modifications, pharmacologic options, surgical options, and hyperbaric oxygen therapy on improving lower extremity perfusion in the patient with an arterial ulcer.

9. Identify options and guidelines for effective “offloading” of plantar surface ulcers.

10. Explain why debridement is contraindicated in a non-infected ischemic ulcer covered with dry eschar.

11. Describe clinical characteristics and management options for venous dermatitis and Charcot fracture.

12. Describe indications for referral to vascular surgeon, podiatrist, orthotist, and dermatologist.

13. Identify indications that a lower extremity ulcer is “atypical” and requires additional diagnostic workup and/or medical-surgical intervention.

Content Outline

1. Introduction/Assessment

- Common types of lower extremity ulcers
- Importance accurate assessment as basis for appropriate management
  - General appearance (trophic changes, hair, nail, and skin characteristics)
  - Veins
  - Skin color, temperature, integrity
  - Edema
  - Peri-wound skin: s/s of infection, maceration, denudation, callus, yeast rash
- Functional sensory status
  - Pain: severity at baseline and procedural; Character of pain: type, location, onset, duration; exacerbating and relieving factors
- Sensorimotor assessment
  - Sensory testing with Semmes-Weinstein monofilament
  - Indications, frequency, procedure, interpretation of data, application to clinical practice)
  - Vibratory testing
  - Proprioception
  - Range of motion (ROM of ankle joint)
  - Deformities, callus formation
  - Footwear (fit, wear patterns, and protection provided)
- Perfusion
  - Elevation pallor and/or dependent rubor
  - Skin temperature
  - Blood flow (bruit/thrill)
  - Capillary refill
  - Pulses
  - Vascular assessment
    - Non-invasive procedures
    - Ankle Brachial Index (indications, frequency of procedure, interpretation of data, application to clinical practice)
    - Toe-Brachial Index
    - Transcutaneous partial pressure of oxygen (TcPO2)
    - Skin perfusion pressure (SPP)
    - Pulse volume recording (PVR) and Doppler waveforms study (Monophasic, Biphasic, Triphasic signals)
    - Segmental limb pressure (SLP) measurements
    - Magnetic resonance imaging (MRI)
    - Duplex angiography
    - Duplex imaging (venous)]
  - Invasive procedures
    - Computed tomographic angiography (CTA)
    - Arteriography

2. Chronic Venous Insufficiency and Lower Extremity Venous Ulcers

- Prevalence data
- Risk factors for venous disease
- Chronic Venous insufficiency
  - Factors supporting normal venous return
  - Pathophysiology of chronic venous insufficiency
  - Clinical presentation chronic venous insufficiency
- Venous ulcers
  - Theories regarding pathogenesis of Lower Extremity Venous Disease (LEVD)
  - Clinical presentation
  - Factors affecting prognosis for healing
- Principles of medical management
  - Measures to improve venous return
    - Leg elevation
    - Compression therapy (Types of wraps: Multilayer, paste, single layer, long vs. short stretch)

- Static compression
    - Indications and contraindications
    - Therapeutic versus modified level compression
    - Guidelines for application/use of Unna's Boot
    - Guidelines for application/use of layered compression wraps
    - Guidelines for application/use of stockings and orthoses
- Indications, contraindications, and guidelines for use of dynamic compression therapy
- Medications
- Management venous dermatitis
- Exudate management
- Management bacterial loads
- Principles of surgical management (e.g., subfascial endoscopic ligation of perforators)
- Management mixed arterial-venous disease
- Measures to prevent recurrence (patient education, long-term compression, etc.)
- Venous edema versus lymphedema
    - Pathology of lymphedema
    - Relationship between longstanding venous disease and lymphedema
    - Clinical presentation venous insufficiency vs. lymphedema
    - Management lymphedema

3. Arterial Insufficiency and Lower Extremity Arterial Ulcers
    - Prevalence data
    - Risk factors for arterial disease
    - Pathophysiology lower extremity arterial disease
    - Clinical presentation lower extremity arterial disease
    - Arterial ulcers
        - Clinical presentation: location, exudate character, wound bed and wound bed edges
        - Pain: characteristics and full assessment
        - Peri-wound skin: s/s of infection, maceration, denudation, callus, yeast rash
        - Factors affecting prognosis for healing
    - Principles of management
        - Patient education re: measures to improve arterial perfusion
            - Lifestyle modifications (tobacco cessation, exercise, nutrition)
            - Pharmacologic agents
            - Surgical intervention
        - Measures to improve tissue oxygenation: hyperbaric oxygen therapy
        - Measures to prevent additional trauma to compromised limb (proper footwear, professional nail care, etc.)
        - Topical therapy
            - Dry necrotic noninfected ischemic wounds
            - Necrotic infected ischemic wounds
            - Open wounds
        - Indications for amputation

4. Neuropathy and Lower Extremity Neuropathic Ulcers (Lower Extremity Neuropathic Disease, LEND)
    - Pathology of neuropathy
    - Types of neuropathy: Impact and implications
        - Sensory
        - Motor
        - Autonomic
    - Patients at risk for neuropathy/neuropathic ulcers
    - Screening guidelines
    - Clinical presentation of ulcers due to LEND
    - Management principles
        - Offloading/measures to prevent further trauma
        - Tight glucose control (diabetic patient)
        - Identification and management of complications (Charcot, osteomyelitis)
        - Aggressive debridement and infection control
    - Prevention recurrence

        - Patient education regarding preventive foot care and self-management
        - Properly fitted footwear and orthotic devices
        - Appropriate foot and nail care
        - Routine foot inspection

5. Guidelines for Differential Diagnosis of Lower Extremity Ulcers
    - Vascular assessment parameters
        - Indicators soft tissue ischemia (status skin, hair, nails)
        - Pulses
        - Ankle-brachial index; toe-brachial index; toe pressures
        - Transcutaneous oxygen pressures
        - Edema
        - Venous filling time, capillary refill time
    - Sensorimotor assessment parameters
        - Sensory testing with Semmes-Weinstein monofilaments
        - Vibratory testing
        - Proprioception testing
        - Range of motion
        - Deformities, callus formation
        - Footwear (fit, wear patterns, protection provided)
    - Pain assessment
        - Severity (baseline and procedural)
        - Character (type, location, onset, duration)
        - Exacerbating and relieving factors
    - Wound assessment
        - Location
        - Dimensions and depth
        - Tunneling/undermining
        - Status of wound bed (granulating, clean non-granulating, necrotic)
        - Volume and character of exudates
        - Status of wound edges
        - Status of surrounding tissues (S/S infection, maceration, denudation, callus, yeast rash, etc.)
    - Data synthesis/utilization
        - Determination causative factor for ulcer
        - Determination comorbidities/conditions affecting management and potential for healing
        - Development appropriate management plan
            - Based on etiology
            - Modified as needed for comorbidities

6. Assessment and Management Atypical Leg Ulcers
    - Vasculitic ulcers
        - Pathology
        - Clinical presentation
        - Management
    - Inflammatory ulcers (e.g., Pyoderma Gangrenosum)
        - Pathology
        - Clinical presentation
        - Management
    - Blood dyscrasias (e.g., Sickle Cell Ulcers)
        - Pathology
        - Clinical presentation
        - Management
    - Intrinsic disease: Calciphylaxis and Epidermolysis Bullosa
        - Pathology
        - Clinical presentation
        - Management
    - Malignant lesion
        - Common types
        - Clinical presentation
        - Management

- Infection
  - Necrotizing fasciitis
- Immune reactions
  - Toxic Epidermal Necrolysis
  - Graft-versus-Host Disease
- Referral indications
- Patient/caregiver education

7. Allergic/Contact dermatitis
   - Etiology/pathology
   - Risk factors
   - Prevention
   - Clinical presentation
   - Management
   - Referral indications
   - Patient/caregiver indications

8.Foot and Nail Care for Patient with Ischemia or Neuropathy
- Assessment
- Routine care and education
- Management options for hypertrophic nails, ingrown nails, calluses, onychomycosis

9. Indications for Referral
- Unclear diagnosis
- Failure to respond to initial therapy (or deterioration)
- Medical-surgical intervention indicated

10 Acute Ischemic Wounds
- Duration of onset of pain
- Signs of acute limb ischemia (pain, paralysis, paresthesias, pulselessness, pallor, polar (cold)
- Ischemia and infection (prompt recognition and intervention; re-vascularization

11 Chronic Ischemic Wounds
- Duration of onset of pain
- Closed necrotic non-infected wound
  - Limited to non-healing probability
  - No signs of infection
  - Wound surface is dry and necrotic
  - Refer immediately for debridement if signs and symptoms of infection

12 Charcot Fracture
- Pathophysiology
- Signs and Symptoms
- Stages (Development, Coalescence, Reconstruction)
- Management Guidelines

**Objectives: Wounds Caused by Specific Disease Process**

1. Describe pathology, clinical presentation, and management of lesions/wounds caused by viral, fungal, or bacterial infections.

2. Describe pathology, clinical presentation, and management of bullous lesions.

3. Describe management issues and options related to cutaneous malignancies.

4. Identify measures for prevention and management of radiation dermatitis and extravasation injuries.

5. Describe key issues and guidelines for management of burns.

Content Outline

1. Assessment and Management Wounds Related to Disease or Trauma: Primary and Secondary Skin Lesions
   - Viral lesions (pathology, clinical presentation, management: HSV, VZV)
   - Fungal lesions (pathology, clinical presentation, management: candidiasis, tinea)
   - Skin/tissue breakdown secondary to bacterial infections (pathology, clinical presentation, and management)
     - Cellulitis, folliculitis, bullous impetigo, non-bullous impetigo
     - Necrotizing fasciitis
   - Bullous lesions (pathology, clinical presentation, management)
   - Cutaneous malignancies (clinical presentation and management)
     - Fungating tumors
     - Basal cell carcinoma
     - Squamous cell carcinoma
     - Palliative care as necessary: strategies to control pain; options for atraumatic dressing changes, measures to control and prevent bleeding; measures to control odor)
   - Lesions related to cytotoxic therapies
     - Radiation dermatitis
     - Chemotherapy extravasation
   - Thermal trauma
     - Stages
     - Pathology of burn injuries
     - Criteria for referral to burn center/ Phases of burn care
       - Emergent
       - Acute/wound (use of topical antimicrobials, temporary skin substitutes, pain management, complication (extensive scarring, contractures)
     - Management principles
   - Cold trauma: Frostbite
     - Clinical presentation
     - Management
     - Patient/ caregiver education

2. Indications for Referral

**Objectives: Management Enterocutaneous Fistulas and Percutaneous Tubes**

1. Describe causative and contributing factors to fistula development.

2. Describe guidelines for medical management of the patient with an enterocutaneous fistula.

3. Outline criteria and guidelines for promotion of spontaneous fistula closure.

4. Explain the significance of pseudostoma formation in the patient with a fistula

5. Discuss indications for surgical closure of a fistula.

6. Develop and implement individualized management plan for the fistula patient that provides for containment of drainage and odor and protection of perifistular skin.

7. Explain the importance of and options for stabilization of percutaneous tubes.

8. Recommend or provide appropriate care for the individual with peritubular skin breakdown, hypertrophic granulation tissue, and peritubular leakage.

9. Describe guidelines for replacement of gastrostomy tube at bedside by nurse.

Content Outline

1. Enterocutaneous Fistula Management
   - Causative and contributing factors
   - Classification systems
   - Initial management (diagnostic workup, assessment for factors that would prevent spontaneous closure, management infectious complications, correction fluid-electrolyte disorders)
   - Measures to promote fistula closure (nutritional support, NPO status, negative pressure wound therapy) for patient with potential for spontaneous closure
   - Indications for surgical repair of fistula
   - Guidelines for containment of drainage and odor and maintenance skin integrity
2. Percutaneous Tube Management
   - Common types of percutaneous tubes (biliary, nephrostomy, gastrostomy)
   - Placement techniques: PEG, Surgical techniques, Interventional radiology
   - Guidelines for site care
   - Stabilization: Importance and options
   - Strategies for preventing and managing complications
     - Tube migration
     - Tract erosion and peritubular leakage
     - Peritubular skin breakdown
     - Hypertrophic granulation tissue
   - Strategies for maintaining tube patency
   - Guidelines for replacement of gastrostomy tube at bedside by nurse

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP

# ABDOMINAL STOMA MANAGEMENT: NURSING INDIVIDUALS WITH BOWEL AND BLADDER DISORDERS (WOC NURSING II)

## TOPICAL OUTLINE

**Objectives for Ostomy Curriculum Blueprint: Fecal and Urinary Diversions**

1. Utilize knowledge of GI/GU anatomy and physiology to provide appropriate management and education for the patient requiring a urinary or fecal diversion.

2. Explain the pathology, clinical presentation, and management of each of the following (to include indications for fecal or urinary diversion):
   - Low level rectal cancer;
   - Mid to high level rectal cancer
   - Crohn's disease;
   - Ulcerative colitis;
   - Familial adenomatous polyposis
   - Bowel perforation due to trauma or acute inflammation (e.g., gunshot wound to abdomen; diverticulitis with perforation; severe radiation enteritis; necrotizing enterocolitis; etc)
   - Lesions/processes resulting in bowel obstruction (tumors; volvulus; intestinal atresia; imperforate anus; etc)
   - Intractable fecal incontinence due to neurogenic bowel
   - Colonic inertia (congenital or acquired megacolon)
   - Bladder cancer (e.g., transitional cell carcinoma of bladder)
   - Inflammatory conditions involving bladder (radiation cystitis, interstitial cystitis)
   - Intractable urinary incontinence due to neurogenic bladder
   - Congenital anomalies involving urinary tract (bladder exstrophy, posterior urethral valves; etc.)

3. Describe each of the following surgical procedures: abdominal-perineal resection; low anterior resection; colectomy; proctocolectomy; coloanal anastomosis; IPAA (ileal pouch anal anastomosis); end stoma; loop stoma; loop end stoma; Hartmann's pouch; mucous fistula; strictureplasty; cystectomy; cystoprostatectomy; ureterointestinal conduit; ureterostomy; vesicostomy (cystostomy); nephrostomy; pelvic exenteration (anterior, posterior, and total)

4. Relate individual patient factors and characteristics to the process(es) involved in adaptation to an ostomy.

5. Describe psychosocial, physical, and cognitive barriers to self-care.

6. Discuss the role of the ostomy nurse in promotion of the patient's adaptation to an ostomy.

7. Identify factors to be included in preoperative and postoperative assessment of the ostomy patient.

8. Provide appropriate preoperative education and counseling for the patient scheduled for an ostomy or continent diversion.

9. Utilize knowledge of planned procedure and principles of effective pouching to accurately select and mark stoma sites preoperatively.

10. Utilize assessment data, knowledge of available products, and understanding of pouching principles to establish an effective pouching system for individual patients.

11. Formulate and implement a plan for postoperative education of the ostomy patient and family to include instruction in stoma management and in lifestyle adaptation.

12. Describe diversion-specific care and education to include the following:
    - Patient with urinary diversion: options and guidelines for nighttime management; measures to prevent urinary tract infection; recognition and response to urinary tract infection; recognition and response to urinary tract infection; indications and guidelines for catheterization to obtain urine specimen
    - Patient with ileostomy: measures to prevent alteration in fluid-electrolyte balance; appropriate response to episodes of diarrhea and/or nausea and vomiting; dietary modifications for prevention of food blockage; recognition and response to signs/symptoms food blockage; indications and guidelines for ileal lavage; medication modifications; management of gas and odor
    - Patient with colostomy: management of gas and odor; management of diarrhea; prevention and management of constipation; counseling regarding option for management by routine irrigation (descending/sigmoid colostomy only); education regarding colostomy irrigation procedure and assistance wit irrigation-related issues

13. Explain etiology/pathology, clinical presentation, and management for each of the following peristomal complications:
    - Mechanical trauma
    - Moisture associated dermatitis
    - Irritant contact dermatitis
    - Allergic contact dermatitis
    - Candidiasis
    - Varices (caput medusae)
    - Pseudoverrucous lesions
    - Folliculitis
    - Pyoderma gangrenosum
    - Suture granulomas
    - Mucosal transplantation
    - Unusual peristomal lesions/conditions

14. Explain indications for dermatologic, gastroenterologic, or surgical consultation in the management of peristomal complications.

15. Describe etiology/pathology, clinical presentation, and management for each of the following stomal complications:
    - Hernia
    - Prolapse
    - Necrosis
    - Mucocutaneous separation
    - Retraction
    - Stenosis
    - Trauma/bleeding

16. Identify indications and contraindications for each of the following:
    - Continent ileostomy (Kock Pouch, Barnett Continent Ileal Reservoir, etc.)
    - Ileal pouch anal anastomosis (IPAA, Ileal-Anal Reservoir, J-Pouch, etc.)

17. Formulate a plan for rehabilitative care and education for the patient undergoing construction of a continent ileostomy to include both early postoperative management and long term management.

18. Identify indications and advantages for each of the following: one-stage IPAA; 2-stage IPAA; 3-stage IPAA.

19. Describe critical elements of rehabilitative care and education for the patient undergoing a 2-stage IPAA procedure to include care following Stage 1 and care following Stage 2.

20. Describe current evidence regarding the pathology, prevention, and treatment of pouchitis.

21. Identify indications and options for construction of a continent urinary diversion.

22. Explain the orthotopic neobladder procedure and postoperative management of the neobladder patient to include potential complications and management.

23. Discuss modifications in ostomy care that may be required for each of the following:
    - Patient who is pregnant
    - Patient who is terminally ill
    - Patient receiving radiation or chemotherapy
    - Patient who is morbidly obese

24. Discuss the philosophy and key elements of palliative care for the ostomy patient.

25. Explain specific considerations for the neonatal/pediatric ostomy patient, to include the following: indications for diversion; indications for pouching; guidelines for pouching and skin care; support for parents; teaching methods.

26. Describe or demonstrate correct procedure for stomal catheterization, ileal lavage, and colostomy irrigation.

27. Describe causative and contributing factors to fistula development.

28. Describe guidelines for management of the patient with an enterocutaneous fistula: medical management; promotion of spontaneous closure; indications and guidelines for surgical closure; and principles/ options for containment of drainage and odor and protection of the perifistular skin.

29. Develop and implement individualized management plan for the fistula patient that provides for containment of drainage and odor and protection of perifistular skin.

30. Explain the importance of and options for stabilization of percutaneous tubes.

31. Recommend or provide appropriate care for the individual with peritubular skin breakdown, hypertrophic granulation tissue, and peritubular leakage.

32. Describe guidelines for replacement of gastrostomy tube by nurse.

Content Outline

I. Gastrointestinal Tract: Key Anatomical Structures/Features
   - A. Tissue layers
     1. mucosa
     2. submucosa
     3. muscularis
     4. serosa
   - B. Esophagus
   - C. Abdominal cavity
     1. peritoneum
     2. mesentery
     3. omentum
     4. fascia
   - D. Stomach
   - E. Small Intestine
     1. duodenum
     2. jejunum
     3. ileum
   - F. Colon
     1. ascending
     2. transverse

3. descending

G. Sigmoid
H. Rectum
I. Anus

II. Gastrointestinal Tract: Major Functions and Implications
A. Stomach and Small bowel: Digestion and absorption nutrients
1. Jejunum primary area for nutrient absorption
2. Ileum: Backup role for nutrient absorption; only site for absorption Vitamin B12-intrinsic factor complex and bile salts (terminal ileum)
3. Role of saliva, gastric fluid, intestinal fluid, pancreatic fluid, and bile
4. Critical length of absorptive small bowel for prevention short gut syndrome
5. Low bacterial counts: Implications
B. Colon and Rectum: Storage and elimination of stool
1. Motility patterns in small bowel, right colon, left colon
2. High bacterial counts: Implications
3. Factors contributing to fecal continence: internal and external sphincter function; rectal capacity and compliance; anoderm/sensory awareness
C. Prebiotics, probiotics, synbiotics

III. Urinary System: Key Anatomical Structures/Features

A. Kidneys
B. Ureters
C. Bladder
D. Urethra

IV. Urinary System: Major Functions and Implications
A. Urine formation and elimination
1. Key mechanisms/processes in urine formation
2. Key characteristics normal urine
3. Urinary pH (value of acidic urine in reducing risk of UTI, protecting peristomal skin, and reducing urinary odor; factors contributing to acidic urine)
B. Additional functions of kidneys (maintenance fluid-electrolyte and acid-base balance; maintenance normal B/P; production erythropoietin; etc.)
C. Importance of antireflux mechanisms at bladder trigone in prevention upper tract infection

V. Indications for a Fecal Diversion
A. Rectal cancer/Gynecologic Cancer/Other
1. etiology
2. risk factors
3. screening
4. presentation
5. work up
6. adjuvant treatment
a. radiation
b. chemotherapy
7. surgical treatment
a. low anterior resection with coloanal anastomosis
b. abdominal perineal resection
c. pelvic exenteration (anterior, posterior, Total)
B. Inflammatory Bowel Disease: Crohn’s and Ulcerative Colitis
1. etiology
2. presentation
3. medical management
a. therapeutics
b. nutritional care
c. supportive care
4. surgical management

a. Crohn's disease
    1. resection
    2. strictureplasty
    3. proctocolectomy with ijleostomy
b. Ulcerative colitis
    1. proctocolectomy
    2. ileal pouch anal anastomosis (IPAA)
    3. continent ileostomy

C. Polyposis Syndromes
1. Familial adenomatous polyposis
2. Gardner's syndrome
    - Etiology
    - Presentation
    - Medical Management
    - Surgical Management

D. Diverticular Disease
1. definition
2. risk factors
3. pathophysiology
4. management

E. Radiation Enteritis
1. definition
2. risk factors
3. pathophysiology
4. management

F. Intractable Colitis
1. definition
2. causative factors
3. pathophysiology
4. management

G. Intestinal Obstruction (Volvulus, Intussusception, Intestinal Inertia)
1. definition
2. risk factors
3. pathophysiology
4. management

H. Trauma
1. definition
2. risk factors
3. pathophysiology
4. management

I. Other Indications
1. Spinal cord inury
2. Ovarian cancer
3. Intractable incontinence
4. Colonic inertia
5. Advanced cervical cancer (posterior or total pelvic exenteration)

VI. Indications for a Urinary Diversion
A. Bladder cancer/Gynecological Cancer
1. definition
2. risk factors
3. pathophysiology
4. management

B. Advanced cervical cancer (anterior or total pelvic exenteration)

C. Radiation Cystitis
1. definition
2. risk factors
3. pathophysiology
4. management

D. Interstitial Cystitis
1. definition

2. risk factors
3. pathophysiology
4. management

E. Intractable Incontinence
1. definition
2. risk factors
3. pathophysiology
4. management

F. Trauma

VII. Fecal Stoma Construction
A. Anatomical Location
B. Type
1. End
2. Loop
3. Turnbull End Loop
C. Mucous Fistula

VIII. Urinary Stoma Construction
A. Uretero-intestinal conduit (Ileal and Colon Conduits)
B. Ureterostomy
C. Turnbull loop end
D. Cystostomy
E. Nephrostomy

IX. Fecal
A. APR
B. LAR
C. LAR + colonic J pouch
D. LAR + coloplasty
E. Hartmann's procedure
F. Colectomy (Subtotal colectomy, Left hemicolectomy, Right hemicolectomy)
G. TPC with end ileostomy

X. Urinary
A. Cystectomy

XI. Factors Affecting Rehabilitative Care
A. Impact of ostomy on self-image/self-concept
B. Stages of adaptation process
C. Factors affecting ability to adapt
1. Self-esteem/coping skills
2. Past experience with ostomies/expectations
3. Support provided by significant others
4. Assistance provided by significant others
5. Impact of ostomy visitor
6. Psychosocial/cultural issues
7. Age/developmental stage
D. Sexual dysfunction
1. Potential impact of pelvic dissection on sexual function
2. Potential impact of ostomy on body image/sexual relationships
3. PLISSIT counseling model

XII. Pre operative Preparation of Patient Anticipating a Stoma
A. Patient Assessment
1. understanding of planned procedure
2. diagnosis, prognosis and treatment plan
3. major concerns of patient and family/support
4. barriers to self care (psychological, physical, cognitive)
5. current emotional support

6. understanding of fears
7. learning style/learning level
8. patient's support system

B. Guidelines for Preoperative Education
1. explanation of planned procedure
2. stoma appearance and function
3. overview of management
   a. pouching system management
      1. changing
      2. emptying
   b. importance of peristomal skin management
   c. obtaining and paying for supplies
4. identification of skills to be acquired
5. attention to sexual concerns/explanation of potential sexual dysfunction
6. basic explanations regarding life style issues
7. acknowledgement of normal stages of adjustment

C. Determination of need for referrals
1. ostomy visitor
2. counseling professional

D. Stoma Siting
1. rationale
2. procedural guidelines

XIII. General Post Operative Management of Patient with Fecal or Urinary Diversion

A. Stoma Assessment
1. Construction
   a. end
   b. loop
   c. Turnbull end loop
2. Anatomical location
3. Viability/edema
   a. color
   b. turgor
4. Height
   a. protruding
   b. flush
   c. retracted
5. Size/Shape
6. Location of lumen (stomal os)
7. Mucocutaneous Junction
8. Function
   a. amount
   b. consistency
   c. color

B. Peristomal Skin Assessment
1. integrity
2. abdominal contours

C. Post Operative Issues
1. assessments
   a. bowel sounds/function
   b. pain
   c. wound/incision(s)
   d. respiratory
   e. urinary function
2. ambulation
3. diet
4. impact of laparoscopic approach

XIV: Factors To Consider When Selecting Pouching Systems

A. Stoma
B. Peristomal Skin
C. Type of Diversion
D. Abdominal Contours (Hard vs. Soft/Flaccid
E. Cognition
F. Physical Limitations

XIV. Pouching Principles
- A. Overall Issues
  1. purpose
  2. wear time
  3. fit
- B. Solid Skin Barrier
  1. purpose/definition: indications and guidelines
  2. types
  3. shape
  4. size
- C. Accessory Products: indications and Guidelines
  1. skin barrier paste
  2. skin barrier powder
  3. skin barrier washer
  4. solid skin barrier sheet
  5. belt/binders
  6. liquid skin barrier
  7. liquid adhesives
- D. Pouches
  1. drainable
  2. non drainable
  3. options: length, film, one piece, two piece
  4. features: gas management (flatus filter), closures

XV. Patient Education: Ostomy Management
- A. Assessing readiness
- B. Pouching principles
  1. how to empty
  2. when to empty
  3. indications for pouch change
  4. preparing equipment
  5. assessing peristomal skin
  6. measuring stoma
  7. peristomal skin cleansing
  8. removal of pouching system
  9. placement of pouching system
  10. problem identification, when to seek assistance
- C. Living with a stoma
  1. where to obtain supplies
  2. bathing
  3. clothing
  4. sexual concerns
  5. dietary concerns
  6. medications
  7. dietary
  8. follow up care
- D. Diversion-Specific Patient Management Issues
  1. Temporary fecal diversions (loop ileostomy/colostomy, Hartmann's pouch, ostomy with mucous fistula): Management retained distal bowel segment
  2. Fecal diversion: Principles and options for bowel preps
  3. Colostomy
     a. irrigation (patient selection, contraindications, guidelines)
     b. management of flatus
     c. management of odor

d. prevention/management of diarrhea and constipation

4. Ileostomy
   a. prevention and management food blockage
   b. management of odor
   c. management of flatus
   d. prevention and management of diarrhea
   e. prevention, early recognition, and management fluid-electrolyte imbalance
5. Urostomy
   a. maintenance of acidic urine (benefits and guidelines)
   b. prevention, early recognition, and management infection
   c. management of stents

XVI. Management of Complications

A. Assessment guidelines
   1. History (onset, description of problem, management to date)
   2. Physical examination (inspection of stoma, peristomal skin, peristomal contours in lying and sitting positions, pattern of barrier erosion)
   3. Referral Parameters

B. Peristomal Complications
   1. mechanical damage
      a. etiology
      b. presentation
      c. assessment
      d. management
   2. Moisture associated dermatitis: irritant contact dermatitis
      a. etiology
      b. presentation
      c. assessment
      d. management
   3. Moisture associated dermatitis: pseudoverrucous lesions
      a. etiology
      b. presentation
      c. assessment
      d. management
   4. allergic contact dermatitis
      a. etiology
      b. presentation
      c. assessment
      d. management
   5. candidiasis
      a. etiology
      b. presentation
      c. assessment
      d. management
   6. varices
      a. etiology
      b. presentation
      c. assessment
      d. management
   7. folliculitis
      a. etiology
      b. presentation
      c. assessment
      d. management
   8. pyoderma gangrenosum
      a. etiology
      b. presentation
      c. assessment

d. management

9. suture granulomas
    a. etiology
    b. presentation
    c. assessment
    d. management
10. unusual presentations:
    a. malignancy
        1. etiology
        2. presentation
        3. assessment
        4. management
    b. herpes
        1. etiology
        2. presentation
        3. assessment
        4. management
    c. pemphigus
        1. etiology
        2. presentation
        3. assessment
        4. management
    d. psoriasis
        1. etiology
        2. presentation
        3. assessment
        4. management
    e. unknown etiology

C. Stomal Complications
1. Hernia
    a. etiology
    b. presentation
    c. assessment
    d. management
2. Prolapse
    a. etiology
    b. presentation
    c. assessment
    d. management
3. Necrosis
    a. etiology
    b. presentation
    c. assessment
    d. management
4. Mucocutaneous separation
    a. etiology
    b. presentation
    c. assessment
    d. management
5. Retraction
    a. etiology
    b. presentation
    c. assessment
    d. management
6. Stenosis
    a. etiology
    b. presentation
    c. assessment
    d. management
7. Trauma

a. etiology
b. presentation
c. assessment
d. management

XVII. Continent Diversions and Sphincter-Sparing Procedures: Indications, Construction, and Management

A. Continent Ileostomy (Kock Pouch, BCIR, Etc.)
1. Indications and contraindications
2. Surgical procedure
3. Early postop care
4. Long-term management
a. Intubation guidelines and frequency
b. Current thinking regarding routine irrigation and potential benefits of probiotics
c. Dietary and medication modifications
d. Importance Medic-Alert

B. Ileal Pouch Anal Anastomosis (IPAA, Ileal Anal Reservoir, J Pouch, etc.)
1. Indications and contraindications
2. Surgical procedure (1-stage vs. 2-stage vs. 3-stage)
3. Management following stage 1 of 2-stage or 3-stage procedure
a. Management loop ileostomy
b. Measures to prevent fluid-electrolyte imbalance
c. Sphincter – strengthening exercises
d. Assessment/management anastomotic stricture
4. Management patient with 1-stage procedure/management following Stage 2 of 2-stage procedure (ileostomy takedown)
a. Measures to reduce stool frequency and urgency
b. Measures to protect perianal skin
c. Prevention and management pouchitis

C. Continent Urinary Diversion
1. Indications and contraindications
2. Surgical Procedures (Kock, Indiana, Mitrofanoff, Miami, etc.)
3. Management guidelines
a. Early postop care (management reservoir catheter & stents)
b. Long-term management
i. Intubation frequency and guidelines
ii. Measures to prevent UTI
iii. Medic-Alert

D. Orthotopic Neobladder
1. Indications and contraindications
2. Surgical procedure
3. Early postop management (management reservoir catheter, stents, urethral catheter)
4. Long-term management
a. Instruction in Valsalva-based voiding
b. CIC as needed for incomplete emptying
c. Prevention/management urinary incontinence

XVIII. Ostomy Management in Patient with Medical-Surgical Conditions or Special Circumstances

A. Patient who is pregnant
B. Patient who is terminally ill (end of life)
C. Patient receiving chemotherapy or radiation therapy
D. Patient who is morbidly obese
E. Patient with cognitive deficits
F. Patient with physical limitations (visual acuity, hearing loss)
G. Patient with Ethnic/Cultural Diversity
H. Patient who is child/neonate

XIX. Management of the Neonatal/Pediatric Patient

A. Pathology and management conditions leading to fecal diversion

1. Obstruction secondary to atresias
2. Volvulus
3. Imperforate anus
4. Necrotizing enterocolitis
5. Hirschspring's disease
6. Meconium ileus
7. Biliary atresia

B. Management of fecal diversions
1. Indications for pouching
2. Modifications in pouching technique
3. Appropriate use of ostomy products

C. Pathology and management conditions leading to urinary diversion
1. Posterior ureteral valves
2. Prune belly syndrome
3. Bladder exstrophy/cloacal exstrophy
4. Spina bifida/myelomeningocele (Neural tube defects)

D. Management of urinary diversions
1. Construction and management temporary diversions (vesicostomy/ ureterostomy)
2. Construction and management long-term diversions (continent urinary diversions vs. ileovesicostomy)

E. Rehabilitative issues
1. Support and education for parents/guardians
2. Developmental phase and implications for care and education
3. Appropriate utilization agency and community resources

XX. Enterocutaneous Fistula Management
A. Causative and contributing factors
B. Classification systems
C. Initial management
1. Diagnostic workup
2. Assessment for factors that would prevent spontaneous closure
3. Management infectious complications
4. Correction fluid-electrolyte disorders

D. Measures to promote fistula closure for patient with potential for spontaneous closure
1. NPO status
2. Nutritional support
3. Negative pressure wound therapy

E. Indications for surgical repair of fistula
F. Guidelines for containment of drainage and odor and maintenance skin integrity

XXI. Percutaneous Tube Management
A. Common types of percutaneous tubes (biliary, nephrostomy, gastrostomy) and placement techniques (PEG, surgically placed tube, tube placed by interventional radiology)
B. Guidelines for site care
C. Stabilization: importance and options
D. Strategies for preventing and managing complications
1. Tube migration
2. Tract erosion and peritubular leakage
3. Peritubular skin breakdown
4. Hypertrophic granulation tissue

E. Strategies for maintaining tube patency
F. Guidelines for replacement of gastrostomy tube by nurse

# RUTGERS UNIVERSITY SCHOOL OF NURSING-CAMDEN WOCNEP

# INCONTINENCE MANAGEMENT: NURSING INDIVIDUALS WITH URINARY AND FECAL INCONTINENCE

## TOPICAL OUTLINE

### Objectives: Urinary Incontinence

1. Discuss the impact of incontinence and implications for WOC nurses and other health care providers.
2. Explain the physiology of normal voiding, to include the role of each of the following: Cerebral cortex; pontine micturition center; spinal cord and nerve pathways; bladder; urethral sphincter mechanism; pelvic floor.
3. Explain how kidney, bladder, and sphincter function change with aging, and how these changes affect voiding patterns and continence.
4. Identify goals for assessment of the individual with urinary incontinence.
5. Describe data to be gathered during the patient interview and the significance of these data to accurate diagnosis.
6. Describe key elements of a focused physical exam for the patient with urinary incontinence, to include interpretation of findings.
7. Describe data provided by a bladder chart and the importance of a completed bladder chart to assessment and management of the patient with urinary incontinence.
8. Utilize data gathered during the interview and physical assessment to determine appropriate laboratory testing for the patient with urinary incontinence.
9. Describe indications for urodynamic testing and basic interpretation of urodynamic findings.
10. Describe reversible factors contributing to incontinence and implications for assessment and management.
11. Synthesize assessment data to determine type of incontinence/voiding dysfunction and goals for management.
12. Relate the basic pathology of stress urinary incontinence to risk factors, clinical presentation/assessment findings, and treatment options.
13. Differentiate between stress incontinence caused by urethral hypermobility and stress incontinence caused by intrinsic sphincter deficiency in terms of pathology, presentation, and management.
14. Describe indications and guidelines for each of the following: pelvic muscle rehabilitation programs; pessaries; penile compression devices; electrical stimulation/extracorporeal magnetic innervation; surgical procedures to stabilize the urethra and/or bladder neck (retropubic suspension procedures and mid-urethral slings); surgical procedures to compensate for intrinsic sphincter deficiency (compressive slings; periurethral bulking procedures; artificial urinary sphincter).
15. Describe current theories regarding the etiology and pathology of overactive bladder with/without urge incontinence.
16. Describe indications and guidelines for each of the following: Urge inhibition strategies; bladder retraining; anticholinergic medications; topical estrogen; electrical stimulation (InterStim).
17. Discuss current thinking regarding the difference between “functional factors contributing to incontinence” and “functional incontinence”.
18. Describe management options for the patient with “functional incontinence”.
19. Identify the pathologic conditions resulting in “total incontinence” and implications for management.
20. Relate the pathology of neurogenic urinary incontinence to clinical presentation, potential complications, and management options.
21. Explain why urodynamic studies are considered essential in the management of patients with neurogenic urinary incontinence.

22. Compare and contract the following management options for the patient with neurogenic incontinence, in terms of advantages, disadvantages, and long-term impact on renal function: Reflex voiding with condom drainage; clean intermittent catheterization; indwelling catheter; continent urinary diversion.
23. Describe the etiology and pathology of urinary retention, to include the potential impact on upper tract function.
24. Explain the significance and methodology for distinguishing between retention caused by impaired detrusor contractility and retention caused by outlet obstruction.
25. Describe indications, mechanisms of action, and points to be included in patient education for each of the following: Alpha-adrenergic antagonists; double-voiding/scheduled voiding; clean intermittent catheterization; indwelling catheter.
26. Differentiate between primary nocturnal enuresis and secondary nocturnal enuresis in terms of clinical presentation and hypothesized etiologic factors.
27. Discuss current options for management of nocturnal enuresis in terms of patient selection criteria and guidelines for implementation.
28. Outline decision-making guidelines regarding treatment priorities for patients with the following mixed conditions: stress-urge; detrusor hyperactivity with impaired contractility; functional incontinence with overactive bladder.
29. Describe guidelines for appropriate selection and utilization of containment and absorptive products to include indications for indwelling catheters and measures to minimize risk of complications.

## I. Urinary Incontinence

### A. Introductory Concepts

1. Prevalence and incidence data
2. Impact of UI (economic and personal)
3. Complications of UI (physical and psychsocial)
4. Barriers to treatment
5. Role of WOC nurse in management of UI

### B. Voiding Physiology

1. Role of cerebral cortex
2. Role of pontine micturition center
3. Role of spinal centers/nerve pathways/neurotransmitters
4. Role of bladder/normal bladder function
    i. Filling phase
    ii. Emptying phase
5. Characteristics and function of urethral sphincter mechanism
    i. Male
    ii. Female
6. Importance pelvic floor support
7. Impact of aging on bladder/sphincter function and continence

### C. Assessment of Patient with UI or Voiding Dysfunction

1. Goals
    a. Screening for conditions that mandate workup/referral
    b. Identification type of UI
    c. Determination goals for treatment
2. Key elements of assessment (focused history, focused physical assessment, bladder chart, labs)
    a. Interview guidelines: Chief complaint; impact on lifestyle; goals for treatment; medical-surgical history/review of systems; fluid intake patterns; use of tobacco products and alcohol; voiding patterns and patterns of leakage; current management; pharmacologic profile; assessment cognitive status (Mini-mental Status Exam as indicated; environmental assessment as indicated; depression screening as indicated)
    b. Focused physical assessment
        1) Percussion and palpation of abdomen

2) Simple pelvic exam (inspection of urethral/vaginal mucosa; digital examination to determine pelvic muscle strength; inspection for clinically significant prolapse, cystocele, or rectocele; any leakage with cough; etc)
3) Anorectal exam (as indicated)
4) Sensorimotor evaluation (as indicated)
5) Perineal skin status
6) Description urinary stream (or Uroflow)
7) Neurologic reflexes (anal wink, bulbocavernosus) as indicated

c. Laboratory studies
1) Urinalysis (Culture & sensitivity as indicated)
2) Post void residual as indicated
a) Indications
b) Catheterized vs bladder scan
c) Interpretation
3) Bladder chart
a) Types
b) Guidelines for completion
c) Guidelines for analysis/interpretation

d. Urodynamic studies
1) Indications
2) General description of study/patient preparation
3) Bedside cystometrogram (indications, guidelines, and interpretation)
a) Voiding cystometrogram
i. Description of procedure
ii. Clinical significance of findings (capacity, compliance, sensory awareness, stability)
b) Pressure-flow study
i. Description of procedure
ii. Clinical significance of findings (normal/explosive flow pattern vs poor/interrupted flow pattern; correlation detrusor contraction pressures and flow rates)
c) Studies evaluating sphincter function: Description and clinical significance
i. Sphincter EMG
ii. Urethral pressure profile
iii. Abdominal leak point pressure
d) Videourodynamics (indications; data provided)

D. Classification Systems for Urinary Incontinence
1. Acute onset/transient incontinence
2. Chronic incontinence

E. Transient (Acute) Incontinence (Definition and Etiology)
1. Contributing factors (DIAPPERS, DRIPP, PPRAISED)
a. Assessment of impact on continence
b. Management guidelines
2. Role of transient factors in chronic UI/implications

Chronic Urinary Incontinence (Various Types)

F. Stress UI (Incontinence associated with Activity)
1. Definition/characteristics
2. Pathology
a. Loss of anatomic support/urethral hypermobility
b. Intrinsic sphincter deficiency
c. Combined issues
d. Postprostatectomy
3. Risk factors
4. Clinical presentation
5. Diagnostic studies/guidelines
6. Management

a. Pelvic muscle rehabilitation with/without biofeedback (indications, guidelines, alternatives, KNACK)
b. Pessaries
c. Urethral inserts/penile compression devices
d. Medications (topical estrogen, sympathomimetics)
e. Electrical stimulation /ExMI
f. Surgical procedures
i. Retropubic suspension procedures
ii. Mid-urethral slings
iii. Pubourethral slings
iv. Periurethral bulking procedures
v. Artificial urinary sphincter

G. Urge UI/Overactive Bladder (OAB)
1. Definition/characteristics
2. Pathology (dry OAB vs. wet OAB): Etiology: Sensory, Motor
3. Risk factors
4. Clinical presentation
5. Diagnostic studies/guidelines
6. Management options/guidelines
a. Elimination bladder irritants
b. Instruction in urge inhibition strategies
c. Bladder retraining (bladder drill)
d. Medications (anticholinergics/antimuscarinics, topical estrogen, Beta-3 Adrenergic Agonist)
e. Electrical stimulation

H. Functional Incontinence
1. Definition/characteristics
2. Pathology
3. Risk factors
4. Clinical presentation
5. Diagnostic studies/guidelines
6. Management options/guidelines
a. Toileting programs: Prompted voiding; Scheduled voiding/habit training
b. Skin care
c. Containment/absorptive products
d. Barrier Modifications

I. Total Incontinence
1. Definition/characteristics
2. Pathology (fistula vs. ectopic ureter)
3. Risk factors
4. Clinical presentation
5. Diagnostic studies/guidelines
6. Management options (surgical correction vs. containment)

J. Neurogenic UI (Reflex Incontinence)
1. Definition/characteristics
2. Pathology (suprasacral spinal lesion)
3. Potential complications/impact on upper tract
4. Etiologic factors
5. Clinical presentation
6. Diagnostic studies/guidelines (importance urodynamic studies)
7. Management options/guidelines
a. Clean intermittent catheterization
b. Condom drainage with reflex voiding (criteria and guidelines)
c. Sphincterotomy/intraurethral stent + condom draining
d. Indwelling catheter
e. Continent urinary diversion
f. Augmentation cystoplasty

K. Urinary Retention (with/without overflow incontinence)
   1. Definition/characteristics
   2. Pathology
      a. Urethral obstruction
      b. Detrusor hypocontractility
   3. Potential complications/impact on upper tract
   4. Etiologic factors
   5. Clinical presentation
   6. Diagnostic studies/guidelines (importance urodynamic studies in differentiating between obstruction and hypocontractility)
   7. Management options/guidelines
      a. Elimination urethral obstruction
      b. Medications (alpha-adrenergic antagonists)
      c. Double-voiding/scheduled voiding
      d. Clean intermittent catheterization
      e. Indwelling catheter

L. Nocturnal Enuresis
   1. Definitions/characteristics
   2. Theories regarding pathology/etiologic factors
   3. Clinical presentation
   4. Diagnostic studies/guidelines
   5. Management options/guidelines
      a. No treatment
      b. Alarm systems + behavioral strategies
      c. Medications (DDAVP, imipramine)
      d. Counseling for parents and child

M. Combined Conditions: Management Priorities and Guidelines
   1. General principles
      a. Protection upper tracts highest priority
      b. Importance patient input in determining tx goals and priorities
   2. Management stress-urge UI
   3. Management detrusor hyperactivity with impaired contractility
   4. Management functional UI with OAB

N. Appropriate Use Containment and Absorptive Products
   1. Indications
   2. Containment devices/options: guidelines for use
      a. External collection devices
      b. Indwelling catheters
   3. Absorptive products (types, selection guidelines)
   4. Skin care guidelines/prevention and management incontinence-associated dermatitis
      a. Key characteristics intact epidermal barrier/impact of incontinence
      b. Definition of IAD: Etiology and risk factors
      c. Preventive care: appropriate use of cleanser, moisturizer, moisture barrier
      d. Clinical Presentation
      e. Differential assessment and management incontinence associated dermatitis
         i. Fungal dermatitis
         ii. Bacterial dermatitis
         iii Viral dermatitis (herpetic)
         iv Intertriginous dermatitis
         v Pressure ulcers

## II. **Fecal Incontinence and Bowel Dysfunction**

Objectives:

1. Discuss the impact of bowel dysfunction or fecal incontinence on lifestyle and quality of life.

2. Explain how each of the following contributes to normal bowel function and fecal continence: Normal peristalsis; sensory awareness of rectal distention and ability to distinguish between solid, liquid, and gaseous contents; internal anal sphincter function; external anal sphincter function; rectal capacity and compliance.
3. Describe criteria and guidelines for use of each of the following: anorectal pouching system; internal drainage systems/bowel management systems
4. Describe options for management of chronic diarrhea.
5. Differentiate among the following in terms of pathology, presentation, and management: normal transit constipation; slow transit constipation; and obstructed defecation.
6. Describe current options for management of the patient with Irritable Bowel Syndrome.
7. Relate the underlying pathology to management options for each of the following: Passive incontinence; urge incontinence; seepage and soiling.
8. Describe data to be gathered during the interview and physical assessment that provide insight into each of the following: peristaltic function; sensory awareness; sphincter function; rectal capacity and compliance.
9. Synthesize data obtained during patient assessment to determine pattern of fecal incontinence.
10. Explain indications and guidelines for each of the following: Colonic cleanout program; sphincter exercises; instruction in urge inhibition; biofeedback; stimulated defecation program.
11. Describe the pathology and management for the child with retentive encopresis.
12. Identify options for the patient with refractory fecal incontinence.

## I. Fecal Incontinence and Bowel Dysfunction- Content Outline

A. General Concepts
   1. Statistics regarding prevalence and incidence
   2. Impact on quality of life/implications for management

A1. GI System: Major Components
(Tissue layers, esophagus, abdominal cavity, stomach, small intestine, colon, anus)

A2. Gastrointestinal Tract: Major Functions and Implications
(Stomach and small bowel: digestion and absorption nutrients)
(Jejenum: primary area for nutrient absorption)
(Ileum: backup role for nutrient absorption, only site for Vitamin B12 absorption, bile salts (terminal ileum); role of saliva, gastric fluid, intestinal fluid, pancreatic fluid and bile, critical length of absorptive small bowel for prevention of short gut syndrome; low bacterial counts: implications
Colon and rectum; storage and elimination of stool
(motility patterns in small bowel, right colon, left colon; high bacterial counts and implications;

B. Normal Defecation: Factors Contributing to Fecal Continence
   1. Role of normal peristalsis/normal stool consistency
   2. Importance normal sensory function
   3. Impact normal sphincter function
      a. Internal anal sphincter
      b. External anal sphincter
   4. Impact rectal capacity and compliance
   5. Effects of environmental and social factors
   6. Process normal defecation

C. Common Types of Bowel Dysfunction (Disordered Defecation)
   1. Diarrhea
      a. Definition
      b. Acute
         i. Etiologic factors (infection, gastroenteritis, acute exacerbation of chronic disease; atrophy of villi: enteral feedings or malnourishment)
         ii. Management issues and options: measures to thicken stool; skin care; containment (pouching vs. bowel management systems)
      c. Chronic
         i. Etiologic factors (IBS, IBD, specific food intolerances (e.g., lactose)
         ii. Stimulant agents in colon: bile salts, unrecognized peristalsis, magnesium salts, sorbitol, other laxatives
         iii Radiation enteritis

iv. Assessment guidelines
v. Management options (correction underlying problem; measures to thicken stool; antidiarrheals; gastroenterology consult; skin care, fecal pouching)

2. Constipation
   a. Definition
   b. Pathology and presentation
      i. Normal transit constipation
      ii. Slow transit constipation
      iii. Obstructed defecation (Structural anomalies, pelvic floor dyssynergia)
   c. Assessment guidelines
      i. Patient interview
      ii. Physical assessment
      iii. Bowel chart
      iv. Laboratory studies as indicated (colonic motility study; defecography; etc.)
   d. Management options
      i. Normal transit constipation (elimination constipating foods and medications; provision adequate fiber and fluids; patient education regarding bowel function/measures to promote elimination)
      ii. Slow transit constipation (trial of fiber + fluid; osmotic laxatives; stimulant laxatives as needed)
      iii. Obstructed defecation (pessary vs. digital support for rectocele; perineal support for pelvic floor descent; biofeedback and patient education for pelvic floor dyssynergia)
      iv. Options for management refractory constipation (Antegrade Continence enema procedure; Interstim; etc.)

3. Irritable Bowel Syndrome
   a. Definition: Classification and Pattern
   b. Pathology and presentation
      i. Diarrhea predominant
      ii. Constipation predominant
      iii. Alternating diarrhea and constipation: Etiologies: Post-bacterial gastroenteritis and food intolerance
   c. Diagnostic guidelines (Rome Criteria)
   d. Management
      i. Identification and elimination dietary offenders
      ii. Medications
      iii. Education/support/stress management

4. Fecal Incontinence
   a. Types and pathology
      i. Transient incontinence due to diarrhea and/or altered mental status
      ii. Chronic incontinence
         a) Passive incontinence (unrecognized leakage of stool)
         b) Urge incontinence (incontinence associated with intense fecal urgency)
         c) Seepage and soiling (leakage of small amounts of stool occurring without individual's awareness)
   b. Assessment guidelines
      i. Patient interview/history
      ii. Focused physical examination
      iii. Bowel chart
      iv. Laboratory/radiologic/anorectal function studies as indicated
      v. Data analysis
         a) Analysis peristaltic function (history; bowel chart)
         b) Analysis sensory awareness (history; physical exam)
         c) Analysis sphincter function (history; physical exam)
         d) Analysis rectal capacity/compliance (history; anorectal function studies)
         e) Determination incontinence pattern (passive vs. urge. Vs. seepage and soiling)
   c. Management guidelines
      i. Passive incontinence due to sensorimotor dysfunction
         a) Measures to normalize stool consistency

b) Stimulated defecation programs

ii. Urge incontinence
   a) Patient education regarding urge control strategies
   b) Sphincter exercises for weak sphincter (with or without biofeedback)
   c) Surgical repair damaged sphincter

iii. Seepage and soiling
   a) Measures to keep stool soft but formed
   b) Biofeedback to improve sensory awareness

iv. Management options for refractory incontinence
   a) Antegrade continence enema procedure
   b) Colostomy

v. Skin care and containment options

vi. Importance education and support for all patients

5. Encopresis
   a. Definitions
      i. Primary vs. secondary
      ii. Retentive vs. non-retentive
   b. Pathology and clinical presentation
      i. Non-retentive
      ii. Retentive
   c. Assessment guidelines
   d. Management guidelines
      i. Counseling and education for child and family
      ii. Bowel cleanout regimens
      iii. Fiber and fluid to keep stool soft and formed
      iv. Toileting schedule
      v. Short term use of laxatives to prevent recurrent constipation

## Appendix F

# RUTGERS UNIVERSITY
# SCHOOL OF NURSING-CAMDEN WOCNEP

# EVALUATION OF CLINICAL PRACTICUM

Student _____

Clinical Preceptor _____

Facility _____

Date of Clinical Experience _____ to _____

Grade: _____

The clinical practicum is "graded" on a 2-step system: Pass and Fail. Pass means student met objectives at an expected or above expected level. For students receiving a failing grade, the Program Directors, the clinical preceptor, and student will develop a plan (i.e., extra assignments, additional hours) to support student attainment of course objectives.

# Appendix F

**DIRECTIONS: Using the following scale, please indicate your evaluation of the student's performance for each objective. Competencies are organized in relation to course and program objectives.**

**0 = not observed** **1 = unsatisfactory (not competent)**
**2 = need improvement (somewhat competent)** **3 = satisfactory (competent)**

**A. Demonstrates safe, proficient practice in providing WOC nursing care to individuals and families throughout the life span.**

1. Assesses and documents the biopsychosocial need of individuals with: an abdominal stoma, draining wound, fistula, pressure ulcer and incontinence.

   3 2 1 0

2. Analyzes information to interpret client data to recognize critical relationships and outcomes.

   3 2 1 0

3. Applies theoretical principles from sciences, humanities, and WOC nursing in selecting and implementing topical treatment, pouching processes, and containment protocols.

   3 2 1 0

4. Demonstrates knowledge of theoretical concepts related to Wound, Ostomy, and Continence clinical situations.

   3 2 1 0

**B. Utilizes the nursing process to formulate a comprehensive plan of care for individuals and families.**

1. Assesses and documents the behavioral responses of individuals and families to altered states of health.

   3 2 1 0

2. Assesses appropriately prioritized client WOC nursing needs including nursing diagnoses.

   3 2 1 0

3. Establishes short-term and long-term goals for health restoration and rehabilitation with individuals and families.

   3 2 1 0

4. Reassesses nursing interventions for appropriateness and efficacy on a continuing basis.

   3 2 1 0

5. Evaluates decision-making and judgment concerning all aspects of individual care.

3 2 1 0

**C. Integrates the teaching/learning process in providing healthcare to individuals with abdominal stomas, fistulas, draining wounds, pressure sores and incontinence.**

1. Relates the principles of teaching/learning to client's developmental stage in implementing a teaching plan.

3 2 1 0

2. Evaluates objectively teaching effectiveness as evidenced by the individual's understanding and compliance.

3 2 1 0

**D. Communicates effectively with individuals, families and society to maintain and/or restore health.**

1. Communicates effectively with individuals, families and the community in diverse health settings.

3 2 1 0

2. Verbalizes personal attitudes and values with regard to student/patient interaction and student/preceptor interaction.

3 2 1 0

3. Regards sensitively to clients when obtaining WOC nursing data.

3 2 1 0

4. Work collaboratively with clients and preceptor to meet clients WOC nursing needs.

3 2 1 0

5. Maintains records of learning progress and time schedules.

3 2 1 0

6. Documents clinical care experience completely and appropriately.

3 2 1 0

**E. Demonstrates leadership skills, responsibility and accountability for self-directed and continued learning for professional career development.**

1. Assumes the initiative in planning learning experiences.

3 2 1 0

2. Seeks opportunities to meet and expand learning opportunities.

3 2 1 0

3. Incorporates constructive ideas/suggestions to enhance learning experiences.

3 2 1 0

F **Recognizes Wound, Ostomy, and Continence problems as potential research questions for nurses.**

1. Collaborates with preceptor to develop awareness of research foci related to Wound, Ostomy, and Continence nursing.

3 2 1 0

2. Identifies researchable questions related to Wound, Ostomy, and Continence nursing care.

3 2 1 0

**PRECEPTOR'S COMMENTS**

**FUTURE GOALS**

Preceptor's Signature

Date

**STUDENT'S COMMENTS**

**FUTURE GOALS**

Student's Signature

Date

## Appendix G

# RUTGERS UNIVERSITY
# SCHOOL OF NURSING-CAMDEN
# WOCNEP

# CLINICAL PRECEPTOR EVALUATION FORM

Name of Student _____

Name of Preceptor _____

Agency _____

Dates of Clinical Practicum _____ to _____

**DIRECTIONS: PLEASE CIRCLE YOUR RESPONSE TO EACH OF THE FOLLOWING STATEMENTS AS THEY RELATE TO YOUR PRECEPTOR.**

5=Strongly Agree; 4=Agree; 3=Undecided; 2=Disagree; 1=Strongly Disagree

| | | SA | A | U | D | SD |
|---|---|---|---|---|---|---|
| 1) | Demonstrates knowledge of recent developments and research findings related to WOC nursing practice. | 5 | 4 | 3 | 2 | 1 |
| 2) | Presents origin of ideas and concepts pertinent to WOC nursing practice. | 5 | 4 | 3 | 2 | 1 |
| 3) | Discusses alternative points of view regarding Wound, Ostomy, Continence (WOC) nursing issues. | 5 | 4 | 3 | 2 | 1 |
| 4) | Relates clinical learning experiences to course and program objectives. | 5 | 4 | 3 | 2 | 1 |
| 5) | Is well prepared to teach WOC nursing. | 5 | 4 | 3 | 2 | 1 |
| 6) | Explains processes/procedures clearly and succinctly. | 5 | 4 | 3 | 2 | 1 |
| 7) | Answers questions in a careful and precise manner. | 5 | 4 | 3 | 2 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 8) | Exhibits a genuine interest in teaching/ learning issues. | 5 | 4 | 3 | 2 | 1 |
| 9) | Assists student in applying theoretical concepts to clinical situations. | 5 | 4 | 3 | 2 | 1 |
| 10) | Encourages student feedback | 5 | 4 | 3 | 2 | 1 |
| 11) | Invites students to share their knowledge and experiences. | 5 | 4 | 3 | 2 | 1 |
| 12) | Invites criticism of own ideas. | 5 | 4 | 3 | 2 | 1 |
| 13) | Provides criticism to student in a constructive manner. | 5 | 4 | 3 | 2 | 1 |
| 14) | Respects student as professional colleague. | 5 | 4 | 3 | 2 | 1 |
| 15) | Displays self-confidence as a WOC Nurse Specialists and is a good role model. | 5 | 4 | 3 | 2 | 1 |

**ADDITIONAL COMMENTS**