WOUND CARE (80)

1. Comprehensive Assessment (19)
   A. Collect the following information related to patient and family history:
      1. Chief complaint
      2. History of present illness
      3. Pain
      4. Past history
      5. Family history
      6. Social, personal, and developmental history
      7. Nutrition
      8. Allergies
      9. Medications
     10. Review of systems

   B. Perform a problem-focused physical examination by:
      1. Assessing and interpreting wound characteristics
      2. Assessing for indications of infection
      3. Staging pressure ulcers
      4. Assessing pressure ulcers
      5. Assessing lower extremity ulcers (e.g., skin and toenails, sensorimotor status, pulses, and capillary refill)
      6. Assess for foot deformity (e.g., Charcot changes, hammer toes)

   C. Recommend/order and interpret:
      1. Vascular studies
      2. Radiologic studies (e.g., x-ray, MRI, bone scan, ultrasound)
      3. Laboratory studies
      4. Culture and biopsy

   D. Risk assessment and goals
      1. Conduct and interpret risk assessment
      2. Identify patient/family goals and factors affecting care

2. Diagnosis (15)
   A. Differential diagnosis
      1. Determine differential diagnoses

   B. Use assessment to determine a diagnosis related to altered skin integrity:
      1. Pressure ulcers
      2. Extremity ulcers (e.g., lymphedema, vascular insufficiency)
      3. Diabetic wounds
      4. Traumatic injury wounds
      5. Thermal injuries (e.g., burns, radiation)
      6. Atypical wounds
      7. Surgical wounds
      8. Autoimmune-related wounds
      9. Neoplastic wounds
     10. Allergic reactions
     11. Chemical trauma (e.g., incontinence-associated dermatitis)
     12. Mechanical trauma
13. Skin infections (e.g., bacterial, fungal)

3. Planning (10)
   A. Determine wound care management plans
   B. Determine caregiver skills and access
   C. Determine educational needs of patient and caregiver
   D. Determine needed supplies and accessibility
   E. Determine a plan for follow up care

4. Implementation (18)
   A. Health Teaching and Health Promotion
      1. Teach patient and/or caregiver about:
         a. control of risk factors
         b. care and prevention strategies (e.g., trauma, foot care)
      2. Provide anticipatory guidance for diagnostic or therapeutic interventions
   
   B. Consultation and Coordination
      1. Provide consultation to other medical staff on wound care issues
      2. Coordinate clinical practice to meet patient needs
      3. Coordinate available program services

   C. Therapeutic Intervention
      1. Recommend or prescribe:
         a. medications
         b. topical agents
         c. cleansing procedures and solutions
         d. measures to minimize risk of infection
         e. hydrotherapy or pulsed lavage
         f. autolytic debridement
         g. enzymatic debridement (i.e., chemical)
         h. mechanical debridement
         i. surgical debridement
         j. sharp instrument debridement
         k. chemical cauterization
         l. pressure, shear, and friction reduction modalities
         m. hyperbaric oxygenation
         n. growth factor treatment
         o. negative pressure wound therapy
         p. bioengineered tissue products
         q. compression therapy (e.g., pumps, wraps, stockings)

      2. Recommend or prescribe modalities to:
         a. eliminate dead space
         b. reduce bacterial load
         c. control odor
         d. contain drainage and/or maintain moist wound surface

      3. Perform:
         a. sharp instrument debridement
         b. chemical cauterization

      4. Initiate pain control measures

      5. Manage the following systemic factors that affect wound healing:
         a. perfusion
b. nutrition
c. glucose control
d. immune compromise (i.e., immunosuppression)
e. mobility
f. incontinence
g. other systemic factors

D. Referral
   1. Refer for medical/surgical interventions
   2. Refer patient for consultation with other disciplines

5. Evaluation (9)
   A. Evaluate effectiveness of treatment (i.e., in relation to patient and provider goals)
   B. Evaluate cost efficiency of treatment
   C. Revise the plan of care based on evaluation

6. Evaluation (9)
   A. Quality of Practice
      1. Participate on a quality/performance improvement (QPI) team
      2. Use QPI data to make decisions about practice
      3. Use QPI data to facilitate organizational policy and procedure changes
   
   B. Education of the Health Care Team
      1. Identify learning needs
      2. Design educational programs colleagues
      3. Evaluate the effectiveness of education

   C. Self Evaluation of Professional Practice
      1. Provide age appropriate care in a culturally and ethnically sensitive manner
      2. Engage in a formal process to seek feedback about practice
      3. Take action to achieve professional goals

   D. Collaboration and Collegiality
      1. Collaborate with other members of the health care team
      2. Serve as a mentor

   E. Ethics and Advocacy
      1. Serve as a resource to facilitate ethical decision making
      2. Support team decision making related to ethics
      3. Promote patients’ autonomy, dignity, and rights

   F. Research
      1. Use results from evidence-based literature to:
         a. validate current wound care nursing practice
         b. suggest changes to current wound care nursing practice
      2. Participate in clinical research activities (e.g., protocol development, subject selection, data collection, analysis, disseminate results)

   G. Resource Utilization
      1. Evaluate resource options for efficient delivery of care
      2. Assist the patient in identifying and securing services
      3. Utilize community and organizational resources to enhance the plan of care

   H. Leadership
      1. Promotes teamwork and healthy work environments within the organization
      2. Influence decision making bodies regarding wound care issues
      3. Promotes the advancement of the profession through participation in professional organizations
OSTOMY CARE (80)

1. Comprehensive Assessment (17)
   A. Collect the following information related to patient and family history:
      1. Chief complaint
      2. History of present illness
      3. Pain
      4. Past history
      5. Family history
      6. Social, personal, and developmental history
      7. Nutrition
      8. Allergies
      9. Medications
      10. Review of systems
   B. Perform a problem-focused physical examination by:
      1. Assessing stomal characteristics
      2. Assessing peristomal characteristics
      3. Assessing continent diversions/neobladder
      4. Assessing fistula characteristics (location; type, source, and volume of output)
      5. Assessing tubes and drains
      6. Assessing current products being utilized
   C. Recommend/order and interpret:
      1. Radiologic studies
      2. Laboratory studies
      3. Culture and biopsy
   D. Goals
      1. Identify patient/family goals and factors affecting care

2. Diagnosis (20)
   A. Differential Diagnosis
      1. Determine differential diagnoses
   B. Use assessment to determine a diagnosis related to peristomal complications
      1. Allergic dermatitis
      2. Irritant dermatitis
      3. Mechanical trauma
      4. Hernia
      5. Skin infections (e.g., bacterial, fungal)
      6. Pseudoverrucous lesions
      7. Mucosal transplantation
      8. Caput medusa
      9. Atypical complications (e.g. pyoderma gangrenosum, malignancy)
   C. Use assessment to determine a diagnosis related to stomal complications
      1. Necrosis
      2. Bleeding
      3. Mucocutaneous separation
      4. Prolapse
      5. Retraction
      6. Stenosis
      7. Laceration
      8. Melanosis coli
D. Use assessment to determine a diagnosis related to continent urinary diversion complications
   1. Pouchitis
   2. Incontinence
   3. Urinary retention
   4. Urinary tract infections

E. Use assessment to determine a diagnosis related to continent fecal diversion complications
   1. Pouchitis
   2. Perianal/peristomal skin alteration
   3. Incontinence

F. Use assessment to determine a diagnosis related to fistulas
   1. Etiology
   2. Alteration in skin integrity
   3. Fluid and electrolyte imbalance

3. Planning (9)
   A. Determine ostomy management plans
   B. Determine caregiver skills and access
   C. Determine educational needs of patient and caregiver
   D. Determine needed supplies and accessibility
   E. Determine a plan for follow up care

4. Implementation (16)
   A. Health Teaching and Health Promotion
      1. Customize teaching based on developmental stage, readiness to learn, knowledge level, cultural
         background, and learning style.
      2. Provide patient education specific to medical diagnosis and surgical procedure
         a. Medical diagnosis (e.g. cancer, bowel or urinary dysfunction, genetic & congenital disease, necrotizing
            enterocolitis)
         b. Surgical procedure (e.g. colostomy, ileostomy, urostomy, neobladder)
         c. Pouching procedure (application, removal, emptying)
         d. Irrigation (colon continence, mucus management)
         e. Continent stoma intubation
         f. Clean intermittent urethral catheterization
         g. Tube management (e.g. irrigation, stabilization)
         h. Management of retained distal segment of bowel
         i. Dietary modifications (foods and fluids)
         j. Changes in absorption of fluids, medications, and vitamins
         k. Perianal skin care
         l. Control of incontinence
         m. Pelvic floor muscle exercises
         n. Managing activities of daily living
         o. Provide sexual counseling
         p. Signs and symptoms requiring follow-up care (e.g. infection, pouchitis, stomal or peristomal
            complications, bleeding)
   B. Consultation and Coordination
      1. Provide consultation to other medical staff on ostomy care issues
         a. Stoma site marking
      2. Coordinate clinical practice to meet patient needs
      3. Coordinate available program services
   C. Therapeutic Intervention
      1. Recommend or prescribe
a. Medications
b. Non-prescriptive topical agents
c. Products
   1) Containment of urine, stool, fistula effluent
   2) Odor control
   3) Skin protection
d. Irrigation (intestine, internal pouch, rectal stump)
e. Fluid replacement
f. Chemical cauterization
g. Replace a gastrostomy tube in an established tract
h. Dilation

2. Initiate pain control measures

D. Referral
   1. Refer for medical/surgical interventions
   2. Refer patient for consultation with other disciplines
   3. Community and internet resources

5. Evaluation (9)
   A. Evaluate effectiveness of treatment (i.e., in relation to patient and provider goals)
   B. Evaluate cost efficiency of treatment
   C. Revise the plan of care based on evaluation

6. Professional Issues (9)
   A. Quality of Practice
      1. Participate on a quality/performance improvement (QPI) team
      2. Use QPI data to make decisions about practice
      3. Use QPI data to facilitate organizational policy and procedure changes
   
   B. Education of the Health Care Team
      1. Identify learning needs
      2. Design educational programs
      3. Provide education to enhance professional growth of colleagues
      4. Evaluate the effectiveness of education
   
   C. Self Evaluation of Professional Practice
      1. Provide age appropriate care in a culturally and ethnically sensitive manner
      2. Engage in a formal process to seek feedback about practice
      3. Take action to achieve professional goals
   
   D. Collaboration and Collegiality
      1. Collaborate with other members of the health care team
      2. Serve as a mentor
   
   E. Ethics and Advocacy
      1. Serve as a resource to facilitate ethical decision making
      2. Support team decision making related to ethics
      3. Promote patients’ autonomy, dignity, and rights
   
   F. Research
      1. Use results from evidence-based literature to:
         a. validate current ostomy care nursing practice
         b. suggest changes to current ostomy care nursing practice
2. Participate in clinical research activities (e.g., protocol development, subject selection, data collection, analysis, disseminate results)

G. Resource Utilization
1. Evaluate resource options for efficient delivery of care
2. Assist the patient in identifying and securing services
3. Utilize community and organizational resources to enhance the plan of care

H. Leadership
1. Promotes teamwork and healthy work environments within the organization
2. Influence decision making bodies regarding ostomy care issues
3. Promotes the advancement of the profession through participation in professional organizations

CONTINENCE (80)

1. Comprehensive Assessment (18)
   A. Collect the following information related to patient and family history:
      1. Chief complaint
      2. History of present illness
      3. Pain
      4. Past history
      5. Family history
      6. Social, personal, and developmental history
      7. Nutrition and fluid intake
      8. Allergies
      9. Medications
      10. Review of systems

   B. Perform a problem-focused physical examination by:
      1. Assessing cognition
      2. Assessing functional status (e.g., environmental barriers, musculoskeletal [including ambulation], dexterity)
      3. Assessing abdomen
      4. Assessing skin
      5. Urogenital exam – external
      6. Pelvic exam (e.g., pelvic organ prolapse, pelvic muscle strength, infection)
      7. Rectal exam
      8. Neuromuscular testing (e.g., genital sensation, anal wink, bulbocavernous reflex)
      9. External anal sphincter assessment

   C. Recommend/prescribe/perform and interpret
      1. bladder and bowel diaries
      2. laboratory studies (e.g., PSA, LFT, CBC, chemistry)
      3. urine studies (e.g., urinalysis, microbiology, 24-hour creatinine clearance, cytology)
      4. post-void residual urine measurement (by catheter or bladder scan)
      5. urodynamics (e.g., cystometry, uroflowmetry, pressureflow, video)
      6. EMG studies
      7. radiologic procedures (e.g., KUB, voiding cystometrogram, renal ultrasound, renal scan, GI transit)
      8. urethral hypermobility testing (Q-tip during vaginal exam)
      9. provoked stress maneuvers (e.g., cough test, paper towel test)
      10. differentiation of urine from vaginal discharge
      11. differentiation of urethral vs. vesico-vaginal urine loss (e.g., pH, pattern, timing, amount, color)

D. Risk Assessment and Goals
1. Conduct and interpret risk assessment for voiding and defecation dysfunction
2. Identify patient/family goals and factors affecting care

2. Diagnosis  (19)
   A. Determine differential diagnoses
   B. Use assessment and knowledge of pathophysiology to determine a diagnosis of:
      1. Urinary incontinence
         a. Transient
         b. Stress
         c. Urge (e.g., OAB wet)
         d. Mixed incontinence
         e. Retention with overflow (e.g., BOO [anatomic or DSD], Detrusor hypocontractility)
         f. Reflex
         g. Nocturnal enuresis
         h. Functional
         i. Post-prostatectomy
      2. Other genito-urinary, lower GI dysfunction
         a. Detrusor hyperactivity with impaired contractility
         b. Neurogenic bladder with and without detrusor sphincter dyssynergia
         c. Nocturia
         d. Urgency/frequency without leakage
         e. Bladder and pelvic pain syndromes
         f. Pelvic relaxation syndromes (e.g., urethral/uterine/rectal prolapse, cystocele, rectocele)

3. Bowel dysfunction
   a. Constipation
   b. Fecal impaction
   c. Fecal incontinence
   d. Diarrhea encopresis

4. Incontinence associated dermatitis
5. Bladder infections (e.g., simple, complex recurrent)

C. Manage situations the may warrant medical evaluation or consultation (e.g. high risk for / possibility of syndromes such as):
   1. Urinary calculi
   2. Pyelonephritis
   3. Pelvic organ prolapse
   4. Genito-urinary cancer
   5. Genito-urinary-gastrointestinal fistula
   6. Upper urinary tract damage related to lower urinary tract dysfunction
   7. Patient open to and condition possibly amenable to surgical intervention
   8. Prostatic enlargement
   9. Unexpected neurologic findings

D. Manage rehabilitation/cure potential

3. Planning  (8)
   A. Determine continence care management plans
   B. Determine caregiver skills and access
   C. Determine educational needs of patient and caregiver
   D. Determine needed supplies and accessibility (e.g., containment and skin care products)
   E. Determine a plan for follow-up care
4. Implementation (16)
   A. Health Teaching and Health Promotion
      1. Teach patient to foster healthy bladder and bowel habits:
         a. dietary and fluid management (including bladder irritants)
         b. emptying maneuvers
         c. bladder and bowel training program
         d. skin care - topical treatment for prevention
   B. Consultation and Coordination
      1. Provide consultation to other medical staff on voiding and defecation issues
      2. Coordinate clinical practice to meet patient needs
      3. Coordinate available program services
   C. Therapeutic Intervention
      1. Recommend or prescribe and instruct on
         a. medications (e.g., bladder relaxants, antibiotics, hormonal, bowel)
         b. surgical evaluation
         c. toileting programs (e.g., bladder training, scheduled toileting, prompted voiding)
         d. containment products and devices
         e. environmental modifications (e.g., bedside commode, urinal, clothing)
         f. prevention strategies to maintain optimal bowel function
         g. lifestyle modifications (e.g., diet, fluids, exercise)
         h. measures to protect skin
      2. Recommend/prescribe/perform and instruct
         a. pessary fitting and care
         b. urgency suppression techniques (e.g., quick flicks, distraction)
         c. catheterization (e.g., clean intermittent, indwelling)
         d. suprapubic catheter care
         e. the "Knack"
         f. pelvic muscle rehabilitation including
            (1) electrical stimulation
            (2) biofeedback
      3. Instruct on self-care modalities for bowel dysfunction
         a. prevention strategies to maintain optimal bowel function
         b. lifestyle modifications (e.g., diet, fluids, exercise)
         c. pharmacologic management of bowel dysfunction
         d. pelvic muscle exercises
         e. skin protection
         f. bowel cleansing
         g. sensory motor re-education (including biofeedback and manometer)
      4. Manage the following systemic factors that affect continence:
         a. Impaired glucose control
         b. Impaired mobility
         c. Neuromuscular diseases (e.g., MS, Parkinson’s, SCI)
         d. Altered nutrition/absorption
         e. Pain
   5. Evaluation (10)
      A. Evaluate effectiveness of treatment (i.e., in relation to patient and provider goals)
      B. Evaluate cost efficiency of treatment
      C. Revise the plan of care based on evaluation
6. Professional Issues (9)

A. Quality of Practice
   1. Participate on a quality/performance improvement (QPI) team
   2. Use QPI data to make decisions about practice
   3. Use QPI data to facilitate organizational policy and procedure changes

B. Education of the Health Care Team
   1. Identify learning needs
   2. Design educational programs
   3. Provide education to enhance professional growth of colleagues
   4. Evaluate the effectiveness of education

C. Self Evaluation of Professional Practice
   1. Provide age appropriate care in a culturally and ethnically sensitive manner
   2. Engage in a formal process to seek feedback about practice
   3. Take action to achieve professional goals

D. Collaboration and Collegiality
   1. Collaborate with other members of the health care team
   2. Serve as a mentor

E. Ethics and Advocacy
   1. Serve as a resource to facilitate ethical decision making
   2. Support team decision making related to ethics
   3. Promote patients' autonomy, dignity, and rights

F. Research
   1. Use results from evidence-based literature to:
      a. validate current continence care nursing practice
      b. suggest changes to current continence care nursing practice
   2. Participate in clinical research activities (e.g., protocol development, subject selection, data collection, analysis, disseminate results)

G. Resource Utilization
   1. Evaluate resource options for efficient delivery of care
   2. Assist the patient in identifying and securing services
   3. Utilize community and organizational resources to enhance the plan of care

H. Leadership
   1. Promotes teamwork and healthy work environments within the organization
   2. Influence decision making bodies regarding continence care issues
   3. Promotes the advancement of the profession through participation in professional organizations