Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Hannah Smith Day/Date: 8/20/25

Setting: Hospital ☒ Ambulatory Care Home Health Care Other:

WOC nurses function as consultants and develop plans of care for other care givers as a guide to providing care in the WOC nurse's absence. For this assignment, a chart review and assessment information are provided for you. Use this information to write a chart note and to develop a plan of care.

Chart Review/History	*Age/sex*: 61-year-old female *PMH*: Uncontrolled DM *CC*: To ER w complaints of abscess to left labia starting > 1 month ago. States it drained bloody purulent drainage and now has excruciating lower abdominal pain. *Meds*: Insulin daily *Social hx*: Lives alone; denies alcohol, tobacco, or street drug use *Labs/Diagnostics*: CT findings compatible with necrotizing fasciitis arising from left labia majora extending along anterior and posterior aspect of abdominal wall. *Plan*: To OR for wide debridement of necrotizing fasciitis area (debridement of skin, subcutaneous fat and fascia) leaving an extra-large wound to left labia & groin area. Consult to WOC team for possible NPWT.

Assessment/encounter:
LOC: Awake but groggy post IV Morphine pre-dressing
VS: 100^2 92 28; 150/86
Initial interview: Pt. in pain, groggy & does not want to converse. Surgery PA at bedside to assist.

Braden scale

Sensory Perception	4
Moisture	2
Activity	2
Mobility	3
Nutrition	3
Friction/Shear	4
Total	18

Wound assessment:
Moist saline dressing removed.
Location: Left labia/groin/perineal/gluteal areas
Wound type: Post op surgical
Extent of tissue loss: Full thickness
Size & shape: 28 x 40.5 x 9.2 cm
Wound bed tissue: pink and moist with no exposed muscle and tendon noted at wound base
Exudate amount, odor, consistency: small amounts of serosanguineous drainage with no odor
Undermining/tunneling: None

Edges: Attached *Periwound skin:* Intact *Pain:* 10/10 *Plan*: Wound appropriate for NPWT.

Photo:
Education: Develop education below
Suggested consults: None at this time

Using critical evaluation of the provided encounter data, identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

1. Identify what could have been done or done differently regarding assessment data collected, treatment recommendations, consults, referrals, tests, and education.

In regard to assessment data collected, treatment recommendations, consults, referrals, tests, and education, what could have been done differently includes the pain assessment. Although it noted a 10/10 severity, a pre and post pain assessment could have been utilized within the start of the IV morphine drip to determine if it is working to lower the pt's pain level. I would also want to know location of pain and type of pain. Also, the nutritional risk was not fully addressed, with a Braden nutrition score of 3, there was no referral to a dietitian or lab work to assess protein status albumin or prealbumin labs. Social and functional assessments were limited, despite the patient living alone and facing a complex wound care regimen that will likely require assistance; no referral to case management or social work was documented. There was also no details regarding how much insulin the patient requires or an A1C lab result. Lastly, patient education was not documented, including essential topics such as wound care and NPWT, signs of infection, glycemic control. With providing education, I would do so at a time when she is more alert and I would be sure she is able to verbalize understanding of all education topics. For example, I would educate the patient on her current wound status, which is the result of a serious infection known as necrotizing fasciitis that required emergency surgical debridement. This has left her with a large, open post-operative wound involving the left labia, groin, perineal, and gluteal areas. It was explained that the wound is being managed with Negative Pressure Wound Therapy, a specialized dressing that uses gentle suction to help remove fluid, promote tissue growth, and protect the wound from further infection. She was advised that this therapy is essential for healing and must remain sealed and connected to the device at all times, with dressing changes occurring every 48 hours. I would also educate on how to recognize signs of wound infection. She was instructed to immediately report any increasing redness, warmth,

swelling, or pain around the wound, as well as any foul-smelling or discolored drainage. Additional warning signs include fever over 100.4°F, new or worsening pain, and sudden increases in wound bleeding or drainage. These could indicate an infection requiring urgent medical evaluation.

Using the information from the encounter and your critical evaluation develop a plan of care to be executed by other members of the healthcare team in your absence. Statements should be directive and holistic. Write as nursing orders. (For example: *What dressing change regimen would you recommend)?*

2. WOC Plan of Care (include specific products used)

- Cleanse with normal saline using moderate pressure (35 mL syringe + 19G tip)
- Apply no sting barrier film to periwound skin
- Apply a fenestrated wound contact layer to the wound bed
- Cut and apply a black GranuFoam™ dressing appropriate to size to fill the wound bed
- Place the foam into the wound, ensuring contact with the entire wound bed. Avoid overpacking or excessive pressure
- Apply a transparent film dressing, ensuring it extends several centimeters beyond wound edges onto healthy skin, smoothing out all wrinkles or air bubbles to create an airtight seal
- Connect the NPWT device tubing to the foam dressing
- Turn on NPWT device and set the pressure to -125 mmHg continuous pressure
- Document the time of dressing application, pressure setting, and initial wound appearance
- Change NPWT dressing every 48 hours
- If signs of infection are present or wound is highly exudative, change dressing every 24 hours and notify provider
- If the system stops working, check for a full canister, dressing leaks, kinked tubing, low battery, or inactive pump, and troubleshoot by securing connections, reinforcing the dressing, restarting the unit, or lowering it to improve suction. Contact WOC nurse or provider if alarms persist, there's no drainage, signs of infection or bleeding appear, or the dressing becomes loose.

Write a chart note giving careful consideration to the chart review information, how the patient was assessed, the problems, and the rationale behind the plan of care. The WOC nurse consultant/specialist note should begin with why you are seeing the pt; Initial visit for…, follow- up visit for…, evaluation and management of…, etc. Then, describe the visit. Be sure to include any physical assessment, interactions, and specific products used/recommended for use. Write in a manner others will be able to understand and be able to interpret your plan of care.

3. Chart note:

Pt is a 61-year-old female with a past medical history of uncontrolled diabetes mellitus. She presents for initial evaluation and management of a post-operative wound following wide surgical debridement for necrotizing fasciitis originating from the left labia majora with extension into the groin, perineal, and gluteal regions. She reports that the area began as a painful abscess over a month ago, which drained purulent and bloody material, followed by development of severe lower

abdominal pain. She was admitted through the emergency department and taken emergently to the OR for debridement. She now has a large open wound in the left groin and perineal area. Pt currently lives alone and denies alcohol, tobacco, or drug use. She reports no assistance at home and is unlikely to be able to manage wound care independently. Current medications include daily insulin; full medication reconciliation pending. During today's visit, pt is awake but groggy, having recently received IV morphine for dressing pain. She is in visible discomfort and not fully conversational but was cooperative with the assessment. She reports pain as 10/10 during dressing changes. On exam, there is a large post-surgical wound involving the left labia, groin, perineal, and gluteal areas, measuring 28 cm x 40.5 cm x 9.2 cm in an irregular, diffuse shape. Wound bed is pink and moist with healthy granulation tissue and no exposed muscle or tendon. Edges are attached, and there is no undermining or tunneling. A small amount of serosanguineous drainage is present with no odor. Periwound skin is intact without signs of maceration or infection. Wound was gently cleansed with normal saline using sterile technique. Periwound skin was protected with Cavilon® no-sting barrier film. Black GranuFoam™ dressing was applied to the wound bed, and Negative Pressure Wound Therapy (KCI VAC®) was initiated at -125 mmHg continuous suction. Dressing was secured with occlusive drape, and system verified for full seal. Pt was encouraged to receive analgesia 30 minutes prior to future dressing changes due to high pain level. Plan is for NPWT dressing changes every 48–72 hours or sooner if device malfunction or saturation occurs. Given the extensive tissue loss, presence of uncontrolled diabetes, and patient's limited social support, referrals were placed to infectious disease for antibiotic management, endocrinology for glycemic control, nutrition for high-protein dietary optimization, and social work/case management for post-discharge planning. Home health is likely to be necessary or short-term placement in a skilled facility. Education was deferred at this time due to patient's sedation level and pain but will be reinforced on follow-up. Wound is appropriate for NPWT and will be reassessed in 48 hours or sooner if changes in condition occur.

You should have a learning goal for each clinical day. What was your goal or reason for choosing this particular mini case study? Were you able to meet this goal? Why or why not?

4. What was your goal for choosing this case?

My goal was to learn more about negative pressure wound therapy as I had not seen one in my clinical rotation. In this case study I was able to look deeply at a complex situation involving NPWT as well as address what I learned from the mini case series as well as from the PowerPoints and the textbook. Goal was met as I feel much more confident to have a pt with NPWT in practice.

Reviewed by: _____ Date: _____

For instructor use only. Do not remove or edit

CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		

• Identifies why the patient is being seen	✓	
• Describes the encounter including assessment, interactions, any actions, education provided and responses	✓	
• Completes Braden Scale for inpatient encounter	✓	
• Includes pertinent PMH, HPI, current medications and labs	✓	
• Identifies specific products utilized/recommended for use	✓	
• Identifies overall recommendations/plan	✓	
Plan of Care Development:		
• POC is focused and holistic	✓	
• WOC nursing concerns and medical conditions, co-morbidities are incorporated	✓	
• Braden subscales addressed (if pertinent)	✓	
• Statements direct care of the patient in the absence of the WOC nurse	✓	
• Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
• Critical thinking utilized to reflect on patient encounter	✓	
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	