Cleveland Clinic

R. B. Turnbull Jr. MD WOC Nursing Education Program

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Terryann Simpson Day/Date: 01/03/2026

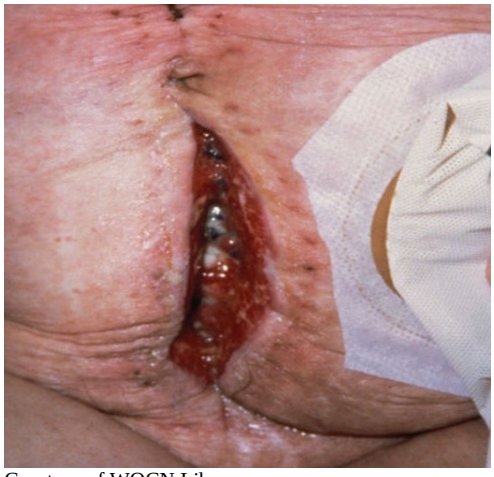
Setting: Hospital • Ambulatory Care ☒ Home Health Care • Other: _____

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*:49-year-old female *PMH*: Uncontrolled DM, obesity, colon cancer with descending colostomy. *CC*: Came to ER for dehisced surgical wound *Meds*: Unknown *Social hx*: Lives alone *Plan:* Referred to wound clinic for treatment plan.

Assessment/encounter:
LOC: Awake, alert, oriented x 3
VS: 98.7°F P 688 R 26
Initial interview: States the "stitches were taken out yesterday at the surgeon's office and now I have a big hole"
Wound assessment:
Location: Mid abdomen
Wound type: Dehisced surgical wound
Extent of tissue loss: Full thickness
Size & shape: 25 x 10 x 5 cm oblong
Wound bed tissue: Red
Exudate amount, odor, consistency: Moderate amount of serosanguineous drainage, no odor. Also noted exudate on blouse
Undermining/tunneling: None
Edges: Attached
Periwound skin: No erythema, induration, fluctuance, denudement. Non-tender
Pain: 8/10 when moving

Photo:



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Education: Discuss below
Suggested consults: Discuss below

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.

There is not much information provided in this patient's chart. Before meeting with the patient, I would review the surgical report for the type of wound closure and whether she had internal sutures as well. When was the surgery completed, and any complications with the surgery or closure? This will also help to determine the treatment plan.

I would start by gathering information surrounding the dehiscence of the wound, such as what she was doing. Wound dehiscence can be caused by many factors, such as moving or coughing without splinting the incision site, abdominal distention, her uncontrolled diabetes, obesity, and engaging in activities too early. Obtain a complete set of vitals (blood pressure, O2, Pulse, temperature, weight, height, and pain level). The medication list, allergies, A1C, and blood sugar; the medical record states uncontrolled diabetes, but did not give management, A1C, blood sugar, or her weight. Labs would also be obtained because there is no documentation of labs to rule out infection or malnutrition, and protein, electrolyte deficiencies.

Physical assessment for the patient and wound is next, as well as her mobility status and ability to care for the wound, because she lives home alone. Wound measurement (width, depth, and length), wound bed for any internal sutures, visible organs due to the depth of the wound, any slough, odor, type, color, and amount of drainage. Assess wound edges and peri-wound skin and obtain wound photograph per facility policy. Contact the surgeon and update him on the information and patient status to develop a treatment plan and schedule a follow-up appointment for the patient to be evaluated by the surgical team.

Based on the picture provided, the peri-wound is intact without denuded areas, and the wound edges are also intact. The wound bed is red with viable tissues. There are a few black and white spots deep in the wound bed, but it is unclear whether these are sutures, slough, or necrotic areas from the picture. Based on the assessment and findings, a wound culture is not needed currently. Patient will need daily wound care services and diabetic/medication management when she returns home, so a referral for wound care services will be made today. Ostomy to LLQ appliance is intact, stoma site visible, and appears red and moist; she denied any issues with stoma or output.

The patient will also need diabetic and wound healing intervention from a dietitian. One of the major contributing factors to poor wound healing is poor diet and uncontrolled diabetes. A referral will be made to a dietitian as well. Patient educated on blood sugar monitoring, an A1C goal of less than 7, and fasting blood sugar of less than 150 daily. Reduction of sweets and carbohydrates, as well as an increase in protein, zinc, vitamin C, and staying hydrated. Patient will also be wearing an abdominal binder for extra support of her abdomen with movement, through how to splint and deep breath or cough, use of her incentive spirometry, ambulation, and rest period. Obtain an order for pain medication if not already on her medication list; the patient verbalized understanding of the education provided.

The wound has a moderate amount of serosanguinous drainage and no odor. Allergy was assessed, and she has no allergies. Wound is cleansed with 0.9% normal saline, wound is loosely packed with Puracol Plus Collagen rope dressing to fill any dead space. The dressing was applied directly to the wound bed and avoids surrounding tissues. Wound is then covered with silicone foam border dressing and changed daily and as needed.

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 wound with normal saline once daily and as needed, pat dry.
Apply Puracol Plus Collagen rope dressing to the wound. Be sure to apply only to the wound bed, pack lightly, and fill any dead space once daily and as needed.
Cover wound with a silicone foam border dressing once daily and as needed.
Follow up with the surgical team as scheduled.
Consult a dietician for education to promote wound healing and glycemic control
Consult home care for wound and ostomy management.
Follow up in the wound care clinic in 1 week for re-evaluation.
Schedule an appointment for follow-up with your PCP for diabetic management.
Continue to follow up with Oncology related to colon cancer.
Apply an abdominal binder with activities.
Use a pillow to splint our abdomen to cough and deep breathe.
Use your incentive spirometry 10 times per hour every hour.

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:

Patient is a 49-year-old female who presented to the office today for evaluation of a dehiscent abdominal wound. She was seen in the ER and referred to the wound care clinic. She reports that she had sutures removed at the surgeon's office yesterday, and today she has an open wound. Medical history includes uncontrolled DM, obesity, and colon cancer with descending colostomy. Labs obtained, and the results are pending.

Medical records showed no medication listed or allergies. She denied any allergies. Medications include Humalog sliding scale, Lantus at bedtime, metformin, and Jardiance to manage her diabetes; she also lists a multivitamin that she takes sometimes. Acetaminophen 500mg 2 tablets every 8 hours as needed, and Oxycodone every 6 hours as needed to manage her pain. A1C in office 10 was 11.3. She reports that she

takes her medication sometimes because she does not like sticking herself with needles, and she is not able to cook for herself, and she lives alone, so when she does it, she eats frozen microwaveable foods. She saw her PCP about 6 months ago because of her health and being busy with other appointments.

The wound and the patient were assessed, and wound care was completed as follows. The wound was cleansed with 0.9% NS, patted dry, and lightly packed with 2 pieces of Puracol Plus Collagen rope dressing to fill any dead space. The dressing was applied directly to the wound bed, making sure to avoid surrounding tissues. Wound is then covered with silicone foam border dressing to be changed daily and as needed.

Patient was medicated for pain before dressing change because she was rating her pain as an 8/10; she tolerated dressing change well. Patient was also educated on diabetic management as well as wound care; the home care agency was consulted for wound care management. The surgery team was consulted, and she has a follow-up appointment. A dietitian referral was also made. The Braden scale was not completed because the patient was seen in an outpatient setting.

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?

I chose this case study because while these types of wounds are common, I did not see any during my clinical rotation. I also knew that it would be a challenge and a learning curve for me to develop the most appropriate treatment plan on my own using different resources. Yes, I did achieve my goals and came up with what I believe is a treatment plan that will be beneficial, convenient, and safe for the patient temporarily until evaluated by the surgeon.

Reviewed by: _____ Date: _____

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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	✓	
• 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:		
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	