

Virtual Journal Entry with Plan of Care & Chart Note

 Student Name: Terryann Simpson Day/Date: 01/13/2026

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

LOC: Awake but groggy post IV Morphine pre-dressing

VS: 100² 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 or tendon noted at the 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.

The patient recently had surgery related to necrotizing fasciitis arising from the left labia majora, extending along the anterior and posterior aspects of the abdominal wall. She is rating her pain 10/10; she appears sedated, this could be from the IV morphine, blood pressure elevated, elevated respiration, and low-grade fever, oxygen on 92%. The frequency and dose of morphine need to be assessed, as elevated respiration could be due to uncontrolled pain. Assess her cognition. Is she able to participate in a conversation at this time? Her history does not list any respiratory diagnosis, such as asthma or COPD, and she does not smoke; she might need to be on O2 short-term while she is on Narcotics. Since the PA is at the bedside, discuss pain management options for long-term goals and comfort because Morphine is not effective. Obtain an order for PRN oxygen at 2-4 L/M via NC use as well.

Obtain the patient's allergy and medication list; her only history listed is uncontrolled diabetes, which can slow the progression of her wound healing. Check for the most recent labs, including A1C, and obtain the medication list to verify the type and dosing of insulin. This information is very vague, and she needs to have the appropriate medication to manage her diabetes. Is she on long-acting or a sliding scale or both? Monitor blood sugar before meals and at bedtime to administer medication safely and effectively.

The patient is now more alert and able to participate in her care. She reports that the Morphine only lasts about 1 hour and is making her very tired. The PA from the surgical team gives the following orders. Medication was changed to Hydrocodone-acetaminophen 5/325 mg 1 tablet every 4-6 hours as needed and morphine 0.3ml 15 minutes before dressing change for breakthrough pain while hospitalized. Humalog insulin based on sliding scale and Lantus 15 units once daily at bedtime. Patient reports that she has no other diagnosis and is not on any other medications.

The WOC nurse will educate the patient on the type of wound that she currently has. NPWT (wound vac, type of sponge, contact layer between the wound and sponge), this is to prevent damage to fragile tissue during dressing change and reduce pain. She will

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also be educated on the twice-weekly and as-needed dressing changes, and how to troubleshoot a leak for the wound vac. If the wound vac is off for more than 2 hours, all the dressings need to be replaced to prevent infection from occurring in the wound. Based on the location of the wound and the fact that she lives alone, she will need a referral for home care for wound vac changes, as well as to follow up with the wound care clinic after discharge. Education will be provided in segments until the time of discharge. Consult with discharge planning and the surgeon on a possible discharge date.

Dietary consult for diabetic management and to promote wound healing while in the hospital, and follow-up after discharge for continued guidance and education. Patient will be educated on dietary options to manage their diabetes and wound healing. This will include monitoring her blood sugar before meals and at bedtime, and administering insulin appropriately as ordered. Eating a diet high in protein (meat, poultry, or fish, low-fat milk, yogurt, eggs, and cheese), low in sugar and carbohydrates, maintain adequate calories and fluid intake, fruits and vegetables. Based on the location of this wound patient might need a urinary diversion system, such as an indwelling catheter, to allow adherence of the wound vac and maintain a seal while preventing contamination of the wound.

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 0.9% normal solution and pat dry.
Apply SENTRY Medical Sofmesh Si Silicone wound contact layer directly to the wound bed to serve as the primary contact layer.
Dry peri wound and drape/frame peri wound with transparent film dressing.
Cut black foam and apply over Sofmesh, making sure foam does not come in contact with peri-wound. Document the number of pieces of foam used in the medical record.
Cover wound with a transparent film dressing.
Cut a small hole in the transparent drape over the wound, and apply a pressure control pad and tubing
Use continuous pressure at 125mmHg on the wound vac and maintain a tight seal.
Change wound vac twice weekly and as needed
Bridge wound vac to the appropriate location for comfort and to prevent the development of pressure injury
Administer breakthrough morphine 15 minutes before dressing change while hospitalized.
An order is to be placed for appropriate dressing supplies before discharge
Follow up with the wound care clinic 1 week after hospital discharge
Consult wound care for dressing change upon discharge
Contact the WOC nurse or the home care agency with questions or concerns
Follow up with the dietician for appropriate education for diabetes and wound management
Follow up with your PCP after discharge for diabetic management and health maintenance.

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:

This patient is a 61-year-old who is currently an inpatient. WOC nurse was consulted today for possible NPWT to a left labial wound. She presented to the ER with an abscess that started over a month ago that she had been caring for herself at home. The abscess became worse, and she came in for evaluation. CT-scan showed necrotizing fasciitis arising from the left labia majora, extending along the anterior and posterior

aspects of the abdominal wall. She had debridement of necrotizing fasciitis area (debridement of skin, subcutaneous fat, and fascia), leaving an extra-large wound to the left labia & groin area. She now has a full-thickness wound measuring 28 x 40.5 x 9.2 cm. Wound bed is pink and moist, with no exposed muscle and tendon noted at the wound base, and small amounts of serosanguineous drainage with no odor. No undermining or tunnelling, no odor, peri-wound intact, and wound edges attached, she is rating her pain at a 10/10. She appeared sedated, and her vital signs were unstable.

Medical history of uncontrolled diabetes. Lab reviewed, surgical notes, allergies, and medication list. She has no allergies and is currently on Lantus 15 units at bedtime and Humalog via sliding scale. Morphine IV to manage her pain, which is not effective. PA is present at the bedside, and we discussed her sedation, uncontrolled pain, and unstable VS. Morphine was moved to PRN, and she was started on oral Hydrocodone-Acetaminophen routine to manage her pain, reduce her drowsiness, as well as PRN oxygen. She was also started on maintenance IV fluids of NS 0.9%.

Patient is now stable, alert, and oriented, vital signs stable, and able to participate in her care and education. She was provided with education on her wound vac while it was being applied as follows:

Cleanse wound with 0.9% normal solution and pat dry.

Apply Sentry Medical Sofmesh Si Silicone wound contact layer directly to the wound bed to serve as the primary contact layer.

Dry peri wound and drape/frame peri wound with transparent film dressing.

Cut black foam and apply over Sofmesh, making sure foam does not encounter with the peri-wound. A total of one piece of black foam was used in the wound bed.

The wound was covered with a transparent film dressing.

A small hole the size of a quarter was cut in a transparent drape over the wound, and the control pad and tubing were applied.

Use continuous pressure at 125mmHg on the wound vac and maintain a tight seal.

Change wound vac twice weekly and as needed

The wound vac tubing was bridged to the upper left thigh using transparent film and black foam for comfort and to prevent any skin breakdown.

Morphine was administered 15 minutes before the dressing change.

Patient tolerated the procedure well, and all her concerns were addressed. Appropriate wound care supplies will be ordered before discharge from the hospital.

She was also provided with dietary reinforcement to manage her diabetes and wound healing. This will include monitoring her blood sugar before meals and at bedtime, and administering insulin appropriately as ordered. Eating a diet high in protein (meat, poultry, or fish, low-fat milk, yogurt, eggs, and cheese), low in sugar and carbohydrates, maintain adequate calories and fluid intake as well as fruits and vegetables.

Total Braden Scale was 18: Sensory perception is 4, moisture 2, Activity 2, mobility 3, nutrition 3, friction and shear 4. She has no limitation with sensory perception, continues to monitor for pain, and instructs her to report any increase in pain. Because of her moisture that can lead to skin impairment, checking bed linens every shift and changing as needed, she can also benefit from a Foley catheter due to the location of her wound. A low-air-loss alternating pressure mattress will also help with moisture and prevent skin issues. The location of her wound is impairing her activity and mobility. Instruct her to stand every hour and reposition every 2 hours while in bed, every 15 minutes while sitting up in a chair. Consult physical therapy for mobility if needed, and have staff perform skin assessments every shift. Her nutrition is adequate; continue to reinforce

nutritional needs as previously discussed. To prevent skin issues from friction and shear, continue to reposition, reduce moisture, and increase mobility as tolerated.

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 learning goal for today and for my final clinical is to choose something that I never did during inpatient clinical. This wound is in a weird location, and there are different things that must be taken into consideration, including bowel and urine, while maintaining a wound vac seal and preventing infection, as well as preventing further skin breakdown. The goal is to heal this wound quickly without complication, and I have formulated a plan to do so. A Foley catheter is not ideal due to its association and high risk of infection; in this situation, it is warranted to promote wound healing and quality of life. Yes, my goal was met in this case study as the patient's wound showed great improvement and was free from infection at her 2-week follow-up in the wound care clinic.

Reviewed by: _____ Date: _____

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CRITICAL ELEMENTS	Completed	Missing
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> Identifies why the patient is being seen 	✓	
<ul style="list-style-type: none"> Describes the encounter including assessment, interactions, any actions, education provided and responses 	✓	
<ul style="list-style-type: none"> Includes pertinent PMH, HPI, current medications and labs 	✓	
<ul style="list-style-type: none"> Identifies specific products utilized/recommended for use 	✓	
<ul style="list-style-type: none"> Identifies overall recommendations/plan 	✓	
Plan of Care Development:		
<ul style="list-style-type: none"> POC is focused and holistic 	✓	
<ul style="list-style-type: none"> WOC nursing concerns and medical conditions, co-morbidities are incorporated 	✓	
<ul style="list-style-type: none"> Braden subscales addressed (if pertinent) 	✓	
<ul style="list-style-type: none"> Statements direct care of the patient in the absence of the WOC nurse 	✓	

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• Directives are written as nursing orders	✓	
Thoughts Related to Visit:		
• Identifies alternatives/what would have done differently	✓	
Learning goal identified	✓	