Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Kimberly Hodgens-Smith Day/Date: 2/6/2026

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*: 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.

A review of the encounter data identifies several opportunities for optimization across assessment, interdisciplinary collaboration, and patient education.

Assessment Data

While wound dimensions and tissue depth were documented, additional assessment elements that could further strengthen clinical decision-making include formal documentation of wound bed tissue percentages (granulation versus nonviable tissue), serial photographic comparison, and more explicit characterization of exudate volume trends. These elements would support more objective monitoring of wound progression over time.

Treatment Recommendations

Early consideration of advanced wound therapies could be evaluated based on wound response; however, the selected moist wound healing approach is appropriate given the full-thickness depth and need for exudate control. Clear contingency planning for situations in which advanced therapies are unavailable is essential and should be explicitly communicated to all care team members.

Consults and Referrals

Earlier referral to a registered dietitian would be beneficial given the metabolic demands of healing a large full-thickness wound. Nutritional optimization, particularly adequate protein and caloric intake, plays a critical role in collagen synthesis and tissue repair. Referral to physical therapy could also be considered to assist with safe mobility and pressure redistribution strategies.

Tests and Diagnostics

If delayed healing or signs of infection were to develop, wound culture and relevant laboratory studies could be considered to guide targeted interventions. Baseline and follow-up laboratory assessment of nutritional markers may further support wound healing efforts.

Education

Expanded patient and caregiver education regarding repositioning schedules, pressure offloading, dressing adherence, and early signs of wound complications could enhance

adherence to the plan of care and reduce the risk of wound deterioration.

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)

Wound Management (Negative Pressure Wound Therapy)

- Cleanse wound with **normal saline** at each dressing change to remove surface debris and allow accurate assessment.
- Apply Sorbact® antimicrobial contact layer directly to the wound bed to manage bioburden and protect viable tissue.
- Apply negative pressure wound therapy (NPWT) to the full-thickness wound per institutional protocol.
  - Use foam appropriate to wound depth and contour.
  - Ensure foam gently fills wound cavity without overpacking.
  - Count and document number of foam pieces placed and removed with each dressing change.
  - Achieve and maintain an airtight seal at all times.
- Set NPWT pressure per provider or institutional guidelines.
- Change NPWT dressing every 48–72 hours or sooner if seal is compromised or dressing becomes saturated.
- The large wound surface area (~1,134 cm^2) and depth with significant wound volume support the use of NPWT to promote wound contraction, manage exudate, and facilitate granulation tissue formation.

NPWT Contingency Plan

- If NPWT is unavailable or therapy is interrupted for greater than 2 hours, remove the NPWT dressing.
- Cleanse wound with normal saline.
- Apply saline-moistened gauze loosely to wound bed and cover with an absorbent secondary dressing.
- Notify WOC nurse or provider of interruption and resume NPWT as soon as feasible.

Skin Integrity / Pressure Injury Prevention

- Reposition patient at least every 2 hours using a documented turning schedule.
- Utilize a pressure redistribution support surface appropriate for patient risk level.
- Offload heels at all times while patient is in bed.
- Use friction- and shear-reducing devices for all repositioning and transfers.

Pain Management

- Assess pain before and after dressing changes.
- Coordinate analgesia with the primary team 30 minutes prior to NPWT dressing changes as indicated.

Nutrition

- Encourage adequate protein and caloric intake to support wound healing.
- Consult registered dietitian to optimize nutritional status related to large full-thickness wound burden.

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:

Reason for Visit:
Initial visit for evaluation and management of a large full-thickness wound.

Encounter Summary:
The patient was evaluated following referral for WOC nurse consultation due to the presence of a large full-thickness wound. Chart review and bedside assessment were completed. The wound was fully exposed, cleansed with normal saline, and assessed for size, depth, tissue quality, drainage characteristics, wound edges, and periwound skin integrity. Findings were reviewed, and an evidence-based wound care regimen was selected to support moist wound healing, bioburden management, and protection of surrounding skin.

Clear, directive nursing orders were developed to guide ongoing care in the absence of the WOC nurse. Contingency planning and escalation criteria were included to support safe continuity of care.

Patient Profile
Adult patient presenting with a full-thickness wound requiring specialized wound assessment and development of a comprehensive plan of care.

Pertinent Medical History
Relevant comorbid conditions provided in the virtual case study were reviewed. These conditions were recognized as contributing factors to impaired wound healing and increased risk for wound deterioration.

Current Medications
Reviewed per case study information.

History of Present Illness
The patient was referred for WOC nurse evaluation due to the presence of a full-thickness wound. Wound characteristics, drainage profile, and periwound condition raised concern for delayed healing and potential progression if not managed with evidence-based interventions. The purpose of this visit was to complete a comprehensive wound assessment, initiate appropriate wound care interventions, and establish clear nursing orders to guide care in the absence of the WOC nurse.

Assessment / Encounter

Level of Consciousness
Patient was awake, alert, and able to participate in the assessment.

Pain Assessment
Pain was assessed per case study information. Anticipated pain related to dressing changes was considered and addressed in the plan of care to support patient comfort and tolerance of wound care.

Wound Assessment
Wound Location: As identified in the virtual case study
Wound Type: Full-thickness wound
Extent of Tissue Loss: Full thickness
Wound Measurements:
Extent of tissue loss: Full thickness
Size & shape: 28 cm (L) × 40.5 cm (W) × 9.2 cm (D), irregular configuration.
Estimated surface area (L×W): 1,134 cm^2 (approximate due to irregular shape).

Estimated volume (L×W×D): 10,432.8 cm³ (approximate due to irregular shape).

Wound Bed:
Viable tissue present, requiring ongoing moisture balance to support granulation and prevent desiccation.

Exudate:
Amount and characteristics as described in the case study.

Odor:
None noted unless otherwise specified.

Edges:
Assessed for attachment and monitored for undermining or tunneling.

Periwound Skin:
Evaluated for erythema, maceration, or breakdown. Preventive skin protection strategies were incorporated into the plan of care.

Braden Risk Assessment (Inpatient)

A Braden Scale assessment was completed based on available case study information. Identified risk factors for pressure injury development were addressed through repositioning, support surface recommendations, and skin protection measures.

Wound Care Delivered

- Patient and wound identity were verified prior to initiating wound care.
- Existing dressing was carefully removed, and the wound was fully exposed to allow complete visualization.
- The wound was cleansed thoroughly with normal saline to remove surface debris and allow accurate assessment of the wound bed.
- Following cleansing, the wound was reassessed for size, depth, tissue quality, drainage characteristics, wound edges, and periwound skin integrity.
- Periwound skin was cleansed and protected with a skin barrier film to reduce risk of maceration and protect intact skin prior to dressing application.
- A Sorbact® antimicrobial contact layer was applied directly to the wound bed to manage bioburden and protect viable tissue.
- Negative pressure wound therapy (NPWT) was applied using foam appropriate to the wound's depth and contour, ensuring the wound cavity was gently filled without overpacking.
- An airtight seal was achieved, and NPWT function was confirmed.
- Dressing components were secured using non-traumatic technique to protect surrounding skin.

Products Used / Recommended

- Normal saline for wound cleansing
- Skin barrier film applied to periwound skin for moisture protection and prevention of maceration
- Sorbact® antimicrobial contact layer to protect wound bed and manage bioburden
- NPWT foam dressing appropriate to wound depth and contour
- NPWT drape to achieve and maintain airtight seal

WOC Nurse Consultant Interventions

- Perform comprehensive wound assessment at each WOC visit, including wound measurements, depth, tissue characteristics, drainage amount and quality, wound

edges, and periwound skin integrity.
- Cleanse the wound with normal saline prior to application of advanced dressings to allow accurate visualization and assessment of the wound bed.
- Apply Sorbact® antimicrobial contact layer directly to the wound bed to manage bioburden and protect viable tissue.
- Apply negative pressure wound therapy (NPWT) using foam appropriate to wound depth and wound geometry, ensuring the wound cavity is gently filled without overpacking.
- Set NPWT pressure per provider order or institutional protocol.
- Minimize the number of foam pieces used; count and document all foam placed and removed with each dressing change.
- Perform NPWT dressing changes every 48–72 hours, or sooner if clinically indicated due to drainage, loss of seal, or wound condition.
- Reassess wound progression at each visit and collaborate with the surgical and primary teams regarding therapy adjustments, escalation, or modification of the wound care plan.

Staff Nursing Orders
- Monitor NPWT system for seal integrity, alarms, and tubing position each shift.
- Ensure NPWT tubing is padded and positioned to prevent pressure injury, kinking, or accidental dislodgement.
- Change NPWT canister when near full; document output volume and characteristics per shift.
- Assess and document pain level before and after dressing changes; coordinate analgesia with the primary team as ordered to support patient tolerance of wound care.
- Notify the WOC nurse or provider for increased drainage, bleeding, foul odor, loss of seal, signs of infection, or patient intolerance of therapy.

NPWT Interruption / Contingency Plan
If NPWT therapy is unavailable or interrupted for greater than 2 hours and cannot be immediately restored:
- Remove the NPWT dressing.
- Cleanse the wound with normal saline.
- Apply saline-moistened gauze loosely to the wound bed.
- Cover with an absorbent secondary dressing.
- Notify the WOC nurse or provider promptly.
- Resume NPWT as soon as therapy becomes available or per provider direction.

Skin Integrity / Pressure Injury Prevention
- Reposition patient at least every 2 hours using a documented turning schedule.
- Utilize a pressure redistribution support surface appropriate for patient risk level.
- Offload heels at all times while patient is in bed.
- Use friction- and shear-reducing devices for all repositioning and transfers.

Pain Management
- Assess pain before and after dressing changes.
- Coordinate analgesia with the primary team 30 minutes prior to wound care as indicated.

Nutrition
- Encourage adequate protein and caloric intake to support wound healing.

- Consult registered dietitian to optimize nutritional status related to large full-thickness wound burden.

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?

The learning goal for this case was to strengthen clinical judgment related to management of large full-thickness wounds using evidence-based dressing selection and clear nursing orders that support continuity of care.

This goal was met through comprehensive assessment, identification of potential gaps in care, and development of a holistic WOC plan of care aligned with current wound management principles.

This case was selected to strengthen clinical reasoning related to the assessment and management of extensive full-thickness wounds, particularly in situations where advanced wound therapies may not be immediately available. During a recent clinical day at Baptist Hospital in Louisville, I observed a CWOC nurse perform a negative pressure wound therapy dressing change for a complex perirectal condyloma wound status post incision and drainage. The challenges related to wound location, depth, and maintenance of an effective seal highlighted the level of expertise required in managing high-risk wounds. This experience reinforced the importance of appropriate dressing selection, pressure injury prevention, nutritional support, and interdisciplinary collaboration, making the case highly applicable to routine WOC nursing practice.

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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	✓	