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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Regina Averyanova Day/Date: 08/24/2025

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:52-year-old female
PMH: morbid obesity, CHF, COPD, PE and lower extremity venous disease with ulcers.
CC: Presented to the ER with bilateral lower extremity edema, cellulitis and ulcers. BLE are erythematous and warm, confirmed cellulitis. Short of breath for past week & uses 4L oxygen
Meds: Currently taking Bumex 2mg BID. Has been taking Tylenol for pain but states it is not helping.
Social hx: Lives alone

Braden score

Sensory Perception	4
Moisture	4
Activity	3
Mobility	3
Nutrition	2
Friction/Shear	3
Total	19

Plan: IV Vancomycin. Morphine for pain. Lasix for CHF. Potassium is low at 2.7. IV potassium ordered. Troponins were normal. COVID neg. Ultrasound r/o DVT's.

Photo: RLE on admission to ED. ABD dressing inplace

Assessment/encounter:
LOC: Alert, awake, & oriented.
Initial interview: Stated both legs have been swollen for a month and are extremely painful to touch. Independently wraps legs daily with ACE bandages, ankle to above wounds. Currently has been suffering with pain and was afraid to come to the hospital because she does not like hospitals, but legs are now weeping, copious amounts of clear drainage. States has not been wearing oxygen.
Wound Assessment
Location: RLE
Size & shape: Round, lateral is 1.2 x 1.3 x 0.1 cm & medial is 1.4 x 1.4 x 0.1 cm
Wound bed tissue: red tissue with small amount yellow tissue on medial wound
Exudate amount, odor, consistency: Large amount serous drainage, thin, no odor
Undermining/tunneling: None
Edges: flat & attached
Periwound skin: Erythematous, but no induration, fluctuance, maceration or denudement.
Pain: 4/10 but >10 on movement
Temperature: BLE warm to touch
Edema: Present bilateral extremities with RLE measuring 40 cm at the calf with reference point of 12 cm from popliteal fossa, 23 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot. LLE measures 43cm at the calf with reference point of 12 cm from popliteal fossa, 25 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot.
Pulse right: Doppled on right leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable
Pulse left: Doppled on left leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable
Monofilament test R foot: All points positive
Monofilament test L foot: All points positive

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.

This 52 year old female patient has lower extremity venous disease (LEVD) with ulcers. Conditions, such as obesity and venous thromboembolism (pulmonary embolism) lead to valve dysfunction (Kelechi et al., 2022, p. 458). Additionally, patient has CHF, which is a significant barrier to healing. This is complicated during this admission by the symptomatic CHF: hypoxia and increased edema in b/l LE. Additionally, due to impaired circulation to lower extremities and open ulcers, patient has developed bacterial skin infection- cellulitis. There are multiple conditions that must be addressed here, and they include symptomatic CHF, cellulitis, venous ulcers, and electrolyte imbalance (potassium). LEVD in this current admission can be classified as class 6 on clinical-etiology-anatomy-pathophysiology system (Kelechi et al., 2022, p. 461).

Careful assessment must be performed to address patient's needs and to address further prevention strategies. On assessment, patient's pedal pulses were palpable, which is a common finding in patients with lower extremity venous disease (Kelechi et al., 2022, p. 460). However, it is also important to perform ankle-brachial index (ABI) to rule out an arterial disease and to determine the level of compression that it is safe to apply to the lower extremities (Kelechi et al., 2022, p. 460). Measuring ABI will not be indicated at this time because patient has significant swelling, pain, and cellulitis of b/l LE. Monofilament testing was done and result was normal, and it showed that patient had normal sensation to b/l feet.

I would need to gather additional information on this patient, such as were there any previous trauma or insect bites to RLE. I would like to know whether patient had any surgical procedures on lower extremities. How long did patient have these ulcers. Are they recurrent? What treatment have she tried besides using ACE bandages? Has she tried to elevate her legs? Has she tried compression stockings? If yes, can she put compression stockings on and take them off? Patient lives alone, does she have any help at home? Does she have anyone who can help her? Patient might benefit from social worker assistance in getting home health services. Does this patient smoke, drink alcohol, or does drugs? In this scenario, it says she hasn't been using supplemental oxygen, what could have been the reason?

Also, it is important to know patient's mobility, range of motion, and gait. She might benefit from seeing a physical therapy for calf muscle exercises which can be beneficial in preventing further ulcer formations (Kelechi et al., 2022, p. 462). Additionally, I would like to know more about patient's nutritional intake. According to Braden scale, patient's nutrition is probably inadequate. This can be an additional barrier to healing. Moreover, optimal dietary program in addition to exercise can help patient lose some weight and prevent further health complications. I also would like for this patient to follow up with the PCP outpatiently and to discuss various weight management options including GLP-1 medication and even bariatric surgery if patient is a candidate. Another important data that can be helpful is patient's lab values, specifically inflammatory biomarkers, proBNP, kidney function, CBC, etc.

Measurement of calf and ankle circumference can help clinicians monitor edema (Kelechi et al., 2022, p. 461). In this scenario, clinician carefully measured b/l LE edema, which is an important data for measuring treatment effectiveness. Knowing whether edema is pitting or non-pitting, localized vs. generalized can help further guide the treatment. Moreover, it is important to rule out secondary lymphedema to b/l LE.

Compression therapy is recommended treatment for LEVD; however, it wouldn't be a recommended treatment for this patient at this time. This patient has symptomatic CHF, and compression therapy would be contraindicated because it can put patient at risk for cardiac overload (Kelechi et al., 2022, p. 476). Additionally, patient has acute cellulitis, and it is best to wait until cellulitis has resolved to try the compression therapy (Kelechi et al., 2022, p. 463).

Once CHF is stable and cellulitis has resolved, healthcare provider should reconsider measuring ABI and initiating compression therapy as a long-term treatment. It would be important to evaluate patient's ability to put on the compression stockings if it is a selected therapy. Occupation therapy can help patient in selecting an appropriate device to apply and remove compression stockings (Kelechi et al., 2022, 469). This patient would benefit from further consults to PCP, cardiology, vascular surgery, bariatric surgery, wound care nurse, registered dietician, physical therapy, occupational therapy, and social worker.

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)

1. Administer pain management as ordered.

2. Gently cleanse the periwound skin with water and pat dry twice a day and PRN.
3. Apply zinc oxide preparation to periwound skin twice a day and PRN (Kelechi et al., 2022, p. 467).
4. Clean the two wounds on RLE with normal saline and pat dry daily and PRN.
5. Apply alginate dressing with silver to the wounds, cover with ABD pad and secure with the Kerlix gauze roll daily and PRN (foam dressing can also be considered instead of ABD and Kerlix). *Contact layer can be applied to an area of the leg that is weeping, followed by ABD pad, and secured with the Kerlix daily and PRN.
6. Elevate the legs above the level of heart for 30 minutes three times a day (Kelechi et al., 2022, p. 466).
7. Measure intake and output (to monitor patient's hydration status)
8. Follow cardiac diet as recommended
9. Weight patient daily at 6 am. Report 3 lbs or more weight gain in one day to the attending provider.
10. Measure calf and ankle circumference every other day at 6 am and document.
11. Maintain low air loss supportive surface on bariatric bed.
12. Perform calf muscle exercises at the frequency that was specified by physical therapy
13. Follow up with the social worker regarding home health care services.
14. Follow up with PCP to discuss pharmacological therapy, such as pentoxifylline in the management of LEVD, GLP-1 in the weight management, etc.
15. Consult vascular surgery, bariatric surgery, cardiology, and pulmonology.
16. Follow up with wound care nurse, registered dietician, physical therapy, and occupational therapy.

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 is an initial visit for a 52 year old female patient who was admitted for b/l LE cellulitis and ulcers. Patient presented to ER with shortness of breath for the past week, b/l LE edema, and ulcers on RLE. Patient is on supplemental home oxygen at 4L via nasal canula. However, patient stated that she hasn't been wearing oxygen at home. Past medical history includes CHF, COPD, morbid obesity, PE, and lower extremity venous disease with ulcers. DVT was ruled out in b/l LE.

On assessment, patient is AAOx4, calm. Patient experienced 4/10 b/l LE pain at rest, and patient received PRN Morphine as ordered. Patient agreed to assessment, treatment, and she was open to education. Patient also ambulated to the bathroom and required some assistance in getting out of bed. Patient required use of a bariatric walker and 1 assist while walking.

On assessment of wounds, there are two wounds on the RLE. First wound is located on the lateral side of the RLE, and the wound is round, measuring 1.2x1.3x0.1 cm. Wound bed has red tissue. Second wound is located medial on the RLE, and the wound is round measuring 1.4x1.4x0.1cm. Wound bed has red tissue with small amount of yellow tissue. There is a large amount of serous drainage from both ulcers, which is thin in consistency, and there is no odor. No undermining and no tunneling present. Edges are flat and attached. Periwound skin is erythematous without induration, fluctuance, maceration, or denudement. Periwound skin was gently cleansed with water and patted dry. Petrolatum was applied to periwound skin. The wounds on RLE were cleansed with normal saline and patted dry. Alginate dressing with silver was applied to lateral and

medial wounds on RLE. Then ABD pad was applied and secured with Kerlix gauze roll.
B/l LE are warm to touch and edematous. Popliteal, dorsalis pedis, and posterior tibial pulses are palpable. Monofilament test showed that sensation is intact on b/l feet. Edema on RLE measures 40 cm at the calf with reference point of 12 cm from popliteal fossa, 23 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot. Edema on LLE measures 43 cm from popliteal fossa, 25 cm at ankle with reference point 2 cm above malleolus, and 20 cm plantar foot. ABI measurements were not done at today's visit due to active cellulitis, pain, and swelling.
Patient was instructed on the importance of elevating legs above the level of the heart for 30 minutes three times a day. Additionally, patient was educated not to cross legs and to wear loose clothing, not tight or constrictive (Kelechi et al., 2022, p. 462). Once patient returns home, patient was educated on how to measure the edema on the legs on a weekly basis and at the same time of the day. Patient has a standing scale at home, and she was encouraged to weigh herself daily in the morning. Then, record her weight, and contact provider if she gains 3 pounds or more in one day. Patient verbalized understanding.
Patient was educated on the routine skin care, specifically on the importance of using a gentle cleanser without fragrances, to gently pat skin dry, and to apply petrolatum on the intact skin (Kelechi et al., 2022, p. 467). Wound care would be continued at home by a visiting nurse once patient is discharged. Patient was educated on the signs and symptoms of CHF and COPD exacerbation and when to notify PCP. Patient verbalized understanding. All the instructions were typed for the patient as a reminder. Patient was educated on the importance to follow up with PCP, cardiology, pulmonology, vascular surgery, and bariatric surgery. Consults were placed to follow up with social worker, wound care nurse, registered dietician, physical therapy, and occupational therapy. Patient verbalized understanding and was in agreement.

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 for choosing this case study was to learn more about lower extremity venous disease and venous ulcers. I wanted to learn more about treatment choices and contraindications. I think I was able to meet this goal because I was able to learn in more detail how to recognize LE venous disease and differentiate it from LE arterial disease. I was able to learn how to manage the LEVD, how to assess the wounds that are associated with venous disease, and how to prevent venous ulcers. I was able to learn more about various types of compression therapy, its indications, and contraindications.

Reference

Kelechi, T. J., Brunette, G., & Brgess, J. J. (2022). Lower extremity venous disease, venous leg ulcers, and lymphedema. In L. L. McNichol, C. R. Ratliff, & S. S. Yates (Eds.). *Wound, Ostomy, and Continence Nurses Society core curriculum: Wound management* (2nd ed., pp. 455-492). Wolter Kluwer.

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	✓	
• 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	✓	