

Virtual Journal Entry with Plan of Care & Chart Note

 Student Name: Sara Waggoner Day/Date: 4 12/4/25

 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	<p><u>Age/sex</u>: 70-year-old male</p> <p><u>PMH</u>: Type 2 Diabetes, lower extremity neuropathy, peripheral vascular disease, and left 5th toe amputation due to osteomyelitis 2 years ago</p> <p><u>CC</u>: Wound on the plantar surface of left foot. Reports wound drainage “worsening” after increased ambulation on a recent family vacation.</p> <p><u>Meds</u>: Metformin 500mg qD, Simvastatin 20mg qD, Acetaminophen 500mg PRN</p> <p><u>Social hx</u>: Lives with wife. Smoked 1 PPD until 10 years ago, no alcohol consumption. Patient reports “occasional” non-compliance with ADA diet.</p> <p><u>Labs</u>: HgA1c at last PCP visit was 7.8%</p> <p>Current wound treatment: Wife changing dressing every other day consisting of fluffed gauze and a conforming bandage. Patient wears sock to further secure the bandage. Reports post op shoe recommended after surgery was “uncomfortable.” Patient has not followed up regarding any adaptive equipment.</p>
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<p>Assessment/encounter:</p> <p><u>LOC</u>: awake, alert, oriented x3</p> <p><u>VS</u>: 98° 84 22. BS 275</p> <p><u>Initial interview</u>: Serous drainage increased from plantar surface of left foot. Patient recently returned from a family trip where he reported an increase in his “normal” walking and exertion due to being at a theme park. Patient noted he was saturating through his sock. Reports concerns due to his DM and history of amputation. Wife performs wound care due to patient inability to reach the area. Current care is every other day dressing of fluffed gauze and a conforming bandage. Tried “adding more gauze” and “soaking foot in Epsom salt for 15 minutes every other night” but wound did not improve. Patient denies sensation to the area.</p> <p><u>Diagnostics</u>: left ABI .91, right ABI .95</p> <p><u>Pulse right</u>: Doppler pulses present on right leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable</p> <p><u>Pulse left</u>: Doppler pulses present on left leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable but weak</p> <p><u>Monofilament test R foot</u>: 10/10 points positive</p> <p><u>Monofilament test L foot</u>: 4/10 points positive indicating a loss of protective sensation noted</p>

Wound assessment:

Location: plantar surface of left foot

Wound type: Suspected neuropathic wound

Extent of tissue loss: full thickness

Size & shape: 3cm x 3cm x 1cm probe to bone

Wound bed tissue: red, smooth

Exudate amount, odor, consistency: moderate amount of serosanguineous drainage, no odor.

Undermining/tunneling: - 1cm circumferentially

Edges: calloused & not attached

Periwound: extensive maceration and callous around wound. No erythema or streaking noted. Cool to the touch.

Pain: none reported

Edema: minimal bilaterally

Photo:



Education: Identify & note in chart notes

Suggested consults: Identify & note in chart notes

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 case study would be stronger if a detailed review of systems and a more comprehensive wound history were gathered. Questions such as duration of wound, previous treatments ordered, and wound center or home health history would be helpful to determine a proper plan of care. The case study states patient has not worn his post op shoe so more information regarding what type of surgery he had and when his surgery was would

have been important information to gather during the assessment.

This patient and his wife require significant education. It is important for this patient to be ordered a home health nurse to assist with dressing changes and wound healing education. It may also benefit the patient for vascular to be consulted since he has abnormal ABI results. His A1C was noted to be 7.8% which is not terrible but according to the American Diabetic Association, a controlled A1C should be less than 7%. A referral to endocrinology is important so that this patient can have more stable blood sugar readings to promote wound healing.

Education:

Patient and wife should be educated to not over compress wound as patient has decreased blood flow to his leg and to much compression could prevent wound from healing.

Patient and wife should be educated on increasing protein in patient's diet to promote wound healing as well as importance of following a diabetic diet.

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 to be used)

Plan:

1. Nurse to cleanse wound with normal saline, apply skin prep to peri-wound, spiral cut Aquacel and gently pack into undermining and lightly fill wound bed. Cover wound with ABD pad and gently secure with kerlix and tape. Dressing to be changed daily and prn for excess drainage. Nurse to educate patient's wife how to properly change dressing.
2. Patient to follow ADA diet.
3. Toe-touch weight bearing as tolerated to avoid pressure on wound.
4. Elevate bilateral lower extremities frequently to promote circulation and increase healing.
5. Keep blood sugars below 150 for optimal wound healing.
6. Encourage 1.5g protein per kg of body weight to promote wound healing.
7. Follow-up with wound center once a week for serial debridement of wound.

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:

CC: Worsening wound drainage

Patient is a 70yo male being seen for initial wound team evaluation of increased drainage from non-healing wound on plantar surface of left foot. Patient has a past medical history of type 2 diabetes, lower extremity

neuropathy, peripheral vascular disease, and left 5th toe amputation due to osteomyelitis 2 years ago. Patient recently went on a family trip to a theme park where he did a lot of walking. Since the trip, he has had an increase in drainage from his left foot wound that is causing his sock to become saturated. Patient's wife has been using fluffed gauze and a conforming bandage to cover the wound. She has been changing the dressing every other day and patient has been soaking his foot in Epsom salt for 15 minutes with dressing changes. Patient is non-compliant with surgical shoe and ADA diet; last A1C was 7.8%. ABI measurements complete left ABI 0.91 and right ABI 0.95. Monofilament test L foot: 4/10 points positive indicating a loss of protective sensation noted, right foot negative.

Allergies:

None listed

Current Medications:

Metformin 500mg qD, Simvastatin 20mg qD, Acetaminophen 500mg PRN

PMHx:

Type 2 Diabetes
lower extremity neuropathy
peripheral vascular disease

Surgical Hx:

Left 5th toe amputation due to osteomyelitis 2 years ago

Soc & Substance Hx: Lives with wife. Smoked 1 PPD until 10 years ago, no alcohol consumption. Patient reports "occasional" non-compliance with ADA diet..

Fam Hx:

None listed.

ROS:

Negative unless otherwise stated in HPI.

O.

Temp 98° HR 84 RR 22. BS 275

GENERAL: A&Ox3. No acute distress.

SKIN: Diabetic ulcer noted to plantar surface of left foot. Full thickness wound with red, smooth wound bed tissue moderate amount of serosanguineous drainage, no odor. 3cm x 3cm x 1cm probe to bone 1cm undermining circumferentially. *Edges:* calloused & not attached Periwound: extensive maceration and callous around wound. No erythema or streaking noted. Cool to the touch.

EXTREMITIES: Minimal edema bilaterally.

Procedures:

WCCT student completed wound care. Removed old fluffed gauze and conforming bandage.

Moderate amount of serosanguinous drainage noted. Cleansed wound with normal saline. Conservative

sharps debridement with loop curette complete. Applied ConvaTec skin barrier to peri-wound. Aquacel cut into spiral shape and gently packed into wound bed and undermining using cotton tip applicator. Wound covered with foam dressing. See wound assessment above.

Most Recent Abnormal Labs:

HgA1c at last PCP visit was 7.8%

Plan:

Diabetic ulcer to plantar surface of left foot:

Nurse to remove old dressing, cleanse wound with normal saline or wound cleanser. Apply ConvaTec skin prep to peri-wound. Apply hydrofera blue to wound bed, loosely fill wound cavity and undermining and overlapping onto peri-wound. Cover wound with ABD pad and gently secure with rolled gauze and tape. Change three times a week and as needed.

Prevention:

Encourage repositioning every two hours

Off-load heels while in bed

Elevate legs to reduce swelling and promote wound healing.

Stay off foot as much as possible.

Follow-up with surgeon and wear post-op shoe.

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 wound case was to learn more about diabetic foot ulcers and how to manage calloused edges. I was able to discuss this case study with my preceptor and we discussed many different dressing options to trial with this patient. I learned that hydroferra blue could be used on this wound to help pull out the edges, soak up drainage, and promote optimal wound bed healing environment. We also discussed that a loop curette could be used to debride the edges of this wound. We determined that serial debridement would be most beneficial to optimize wound healing.

Reviewed by: Mike Klements 12/11/25
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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 	✓	
<ul style="list-style-type: none"> Directives are written as nursing orders 		✓
Thoughts Related to Visit:		
<ul style="list-style-type: none"> Identifies alternatives/what would have done differently 	✓	
Learning goal identified	✓	