Cleveland Clinic

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

Virtual Journal Entry with Plan of Care & Chart Note

Student Name: Angela Bishop Day/Date: 01/18/2025

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*: 70-year-old male *PMH*: Type 2 Diabetes, lower extremity neuropathy, peripheral vascular disease, and left 5th toe amputation due to osteomyelitis 2 years ago *CC*: Wound on the plantar surface of left foot. Reports wound drainage "worsening" after increased ambulation on a recent family vacation. *Meds*: Metformin 500mg qD, Simvastatin 20mg qD, Acetaminophen 500mg PRN *Social hx*: Lives with wife. Smoked 1 PPD until 10 years ago, no alcohol consumption. Patient reports "occasional" non-compliance with ADA diet. *Labs*: HgA1c at last PCP visit was 7.8% 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.

Assessment/encounter:
LOC: awake, alert, oriented x3
VS: 98° 84 22. BS 275
Initial interview: 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.

Diagnostics: left ABI .91, right ABI .95

Pulse right: Doppler pulses present on right leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable

Pulse left: Doppler pulses present on left leg: popliteal, dorsalis pedis, posterior tibial. Pulses palpable but weak

Monofilament test R foot: 10/10 points positive
Monofilament test L foot: 4/10 points positive indicating a loss of protective sensation noted

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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.

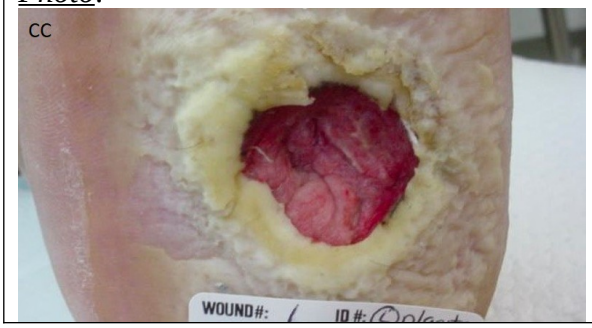
Undermining/tunneling: - 1cm circumferentially
Edges: calloused & not attached

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.

It would be useful to assess for signs of motor neuropathy including foot deformities, the patient's gait, and muscle strength. Also, noting the patient's current footwear would be helpful. The condition of the skin on the foot is important to evaluate as fissures may develop in the presence of autonomic neuropathy. Also, the patient is at increased risk of fungal infection due to his diabetes diagnosis. The location is listed as the

plantar surface, but it would be necessary to know if it was on the forefoot, midfoot, or heel. The picture seems to show an ulcer on the heel.
Using a classification system can help communicate the condition of the ulceration to other providers and also guide treatment. The guidelines from the International Working Group on the Diabetic Foot (IWGDF, 2023) suggest the use of the SINBAD system and also the Wlfl system if ABI information is available. The SINBAD score would be 5/6 with a question about bacterial infection. The Wlfl system would score the wound grade 3, ischemia grade 0, and foot infection grade 0.
Off-loading will be required for wound healing. Due to the question of infection and the high amount of exudate, a total contact cast would not be recommended at this time.
Due to concerns of infection, labs including ESR, CBC, CMP would be recommended to assess infection. X-ray of the foot would be necessary to evaluate for osteomyelitis.
Referral back to primary care of endocrinology for diabetic management for a goal A1C of 7% to help with wound healing.

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)

1. Clean wound and periwound with Skintegrity wound cleanser. Pat periwound skin dry.
2. Protect periwound skin with liquid skin protectant.
3. Lightly pack wound with Opticel ribbon dressing, ensuring that the dressing fills the undermining present at the wound edges.
4. Cover with Optifoam gentle silicone dressing. Change dressing every three days or when dressing becomes saturated or soiled.
5. Off-loading with a knee-high removable walker boot to be worn whenever pressure may be placed on the foot.

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:

History of Present Illness
A 70-year-old male with a history of type 2 diabetes, lower extremity neuropathy, peripheral vascular disease, and left 5th toe amputation due to osteomyelitis 2 years ago presents to the wound clinic with a wound on the plantar surface of his left foot.

The patient reports that the wound drainage has become worse since ambulating more frequently on a recent family vacation where he increased his normal walking and exertion due to being at a theme park. The serous drainage has increased from the plantar surface of his left foot, with the patient noting that it saturates through his sock. He is concerned about this due to his history of diabetes and a history of amputation. The patient denies sensation to the area.

Current wound management is performed by his wife who changes the dressing every other day using fluffed gauze and a conforming bandage. He wears a sock to further secure the bandage. They have tried adding more gauze and soaking the foot in Epsom salt for 15 minutes every other night, but the wound has not improved. He was given a post-op shoe after surgery but it was uncomfortable and he has not followed up regarding any adaptive equipment.

Medical History
- Type 2 diabetes mellitus
- Lower extremity neuropathy
- Peripheral vascular disease

Surgical History
- Left 5th toe amputation due to osteomyelitis 2 years ago

Medications and Supplements
- Metformin 500 mg daily
- Simvastatin 20 mg daily
- Acetaminophen 500 mg as needed for pain

Social History
- Substance Use: Former smoker, one pack per day until 10 years ago; currently does not consume alcohol
- Living Situation: Lives with wife who assists with dressing changes
- Diet: Occasional compliance with ADA diet

Review of Systems
Neurological: Negative for sensation to the plantar surface of left foot. Negative for pain.

Objective
Vital Signs
- Temperature: 98°F
- Heart Rate: 84 bpm
- Respiratory Rate: 22 breaths per minute

Physical Examination
General: Awake, alert and oriented times 3.
Cardiovascular: Doppler pulses present and palpable on the right extremity, including popliteal, dorsalis pedis, and posterior tibial. Left extremity pulses present via doppler, including popliteal, dorsalis pedis and posterior tibial. Left pulses are palpable but weak.
Musculoskeletal: Minimal bilateral edema.
Skin: Present on the plantar surface of the left foot is a full-thickness tissue loss wound measuring 3 centimeters by 3 centimeters by 1 centimeter with probe to bone. Wound bed is red and smooth with moderate serosanguinous drainage without odor. One centimeter circumferentially undermined. Edges are calloused and not attached. Peri-wound shows extensive maceration and callus around the wound. No erythema or streaking noted. Cool to the touch.
Neurological: Monofilament testing to the right foot is 10 of 10 points positive. Monofilament testing to the

left foot is 4 of 10 points positive. Patient denies sensation to the wound area and reports no pain.

Laboratory, Imaging, and Diagnostic Test Results
- ABI testing: Left ABI 0.91, Right ABI 0.95
- Monofilament testing: Right foot 10/10 points positive, Left foot 4/10 points positive
- Hemoglobin A1c: 7.8%

Assessment & Plan
Left foot full-thickness neuropathic ulcer
SINBAD score 5/6. Wlfl system wound grade 3, ischemia grade 0, and foot infection grade 0.
Plan:
- Clean wound and peri-wound area with SkinTegrity Wound Cleanser, pat peri-wound skin dry
- Protect peri-wound skin with Liquid Skin Protectant
- Lightly pack wound with Optacel Ribbon Dressing, ensuring dressing fills undermining at wound edges
- Cover with Optifoam Gentle Silicone Dressing
- Change dressing every 3 days or when saturated or soiled
- Offloading with knee-high removable walker boot to be worn whenever pressure may be placed on foot
- Patient education on strict adherence to wearing offloading boot despite discomfort
- Recommend ESR, CBC, CMP to evaluate for infection and x-ray of left foot
- Discussed that antibiotic may be necessary depending on lab and imaging results
- Referral to infectious disease provider may be needed depending on results

Type 2 diabetes with hyperglycemia
Plan:
- Discuss importance of tighter glycemic control to aid wound healing
- Encourage return to primary care for A1c to be performed 3 months after previous blood draw

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?

Diabetic foot ulcers are another common condition found in mobile primary care. This was another opportunity to create a basic treatment plan for this type of wound. It was interesting to find the International Working Group on the Diabetic Foot guidelines. I found that to be very complete and helpful in learning about these complex wounds and the treatment options.

References

International Working Group on the Diabetic Foot. (2023). *IWGDF guidelines on the prevention and management of diabetes-related foot disease.*

https://iwgdfguidelines.org/wp-content/uploads/2023/07/IWGDF-Guidelines-2023.pdf

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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	✓	