

Community nursing note

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Author	Nursing	Recipient	-

Foot wound dressing review

Date/time: 03/09/2026 09:30

Patient: Maria Santos (63 years, female)

Service: Community Nursing Service

Location: Patient home

Encounter: Wound care - dressing and monitoring

Reason for visit

Home visit for dressing review and monitoring of a foot wound.

Relevant history

Maria has type 2 diabetes, chronic kidney disease stage 3, peripheral neuropathy and heart failure. Documented allergy: penicillin, with angioedema. She was reviewed in the Emergency Department on 27/08/2026 for a diabetic foot infection. Foot X-ray showed no bone destruction; wound culture was collected. She was discharged on clindamycin 450 mg three times daily, with empagliflozin withheld, and advised to keep pressure off the affected foot and return for fever, spreading redness or increasing pain. At High Risk Foot Clinic review on 30/08/2026, redness had reduced, there was no exposed bone, and the wound culture was susceptible to the current antibiotic. The specialist plan was to continue the antibiotic and specialist wound plan.

Visit findings

Foot ulcer reviewed. The ulcer is smaller. No purulent discharge was noted. The healing trajectory is satisfactory, but ongoing care is required.

Care provided

Wound dressing reviewed and wound care provided as per the current community nursing plan. Existing advice to keep pressure off the affected foot remains applicable. No medication changes were made at this visit. Clindamycin remains active at 450 mg three times daily and empagliflozin remains withheld, as previously documented. No new patient advice was recorded at this visit.

Follow-up

Ongoing community nursing dressing and wound measurements are outstanding, due 20/09/2026. High-risk foot clinic follow-up is outstanding, due 20/09/2026. GP diabetes and renal monitoring while empagliflozin is withheld is outstanding, due 15/09/2026. Continue community nursing wound monitoring as planned.