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Daily Journal Entry with Plan of Care & Chart Note

Student Name: ___Bernadette Fulweiler____ Day/Date: __4/11/24__

Chart Review/History	55-year-old homeless male presented to the ER accompanied by pt friend with severe flu-like symptoms and severe shortness of breath 2 days ago. Per patient friend's report, Pt is a 1ppd smoker and "uses oxygen when he has it". Patient friend provided limited history, states patient has been "sick for a few days" and has been "unable to get out of his chair". Denied any known recent ETOH or illicit drug use from patient. Pt is reported ambulatory at base line and noted unable to transfer self due to SOB and fatigue in ER. Pt desaturated and code called in ER. Pt resuscitated and transferred to intensive care unit, intubated, and sedated. Flu+ COVID-19 negative. Patient remains intubated in ICU. Incontinent of stool. External male catheter in use. No skin assessment noted in ER. History of CHF, COPD, arterial disease, AKI and cellulitis to the bilateral lower extremities. Patient is on a low air loss surface. Braden Scale noted to be charted "11" per bedside nurse charting. Medications include vasopressors and a diuretic.

Assessment:

- Intubated and sedated in the intensive care unit.
- Thin, with cachexic appearance, and unkept.
- Bedside RN reports noting a Stage 3 pressure injury to sacrum and buttock during incontinence care this morning. No previous documentation available on injury.
- Sacral foam dressing removed.
- Copious amounts of Desitin barrier cream to area.
- Small amount of fecal incontinence.
- Sacral and buttock area cleansed. Mineral oil used to clean off Desitin noted.
- Open area to sacrum and left upper buttock area.
- Scant serous drainage noted from both open areas.
- Sacral wound shallow with reticular dermis layer visible. Epithelialization. Wound measures 2.0 cm x 1.2cm x 0.2cm.
- Left upper buttock wound measures 0.8 x 0.8 x 0.2cm.
- Photographs taken and placed in chart.

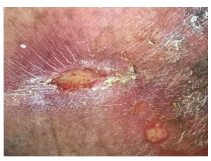

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Chart note:

Patient X is a 55-year-old male with pressure injuries x2 to his sacrum/buttock. X presented 4/09/24 to the ED with severe flu-like symptoms and SOB. Patient currently admitted to the ICU due to respiratory distress, where he is intubated and sedated. Limited history obtained from a friend of the patient, who states that X has been chair-bound and "sick" for the past few days. As per friend, X is ambulatory at baseline, and has not abused ETOH or illicit drugs. Medical history includes smoking, oxygen dependence at baseline, CHF, COPD, arterial disease, AKI, and cellulitis to bilateral lower extremities. Patient has a history of housing insecurity and does not have consistent access to oxygen therapy. Surgical history, lab values, and medications reviewed.

The wound care team was consulted regarding management of the pressure injury to the sacrum/buttocks. On 4/11/24 Sarah Smith, bedside RN documented a stage III pressure injury to the sacrum/buttocks and a score of 11 on the Braden Scale (high risk). There is no previous record of this injury on file.

At this initial visit, the wound was assessed at the bedside at 09:00 AM on 4/11/24 by Bernadette Fulweiler, APRN, CWCN who was assisted by Sarah Smith, RN. The ICU resident Dr. Jones, MD was notified prior to the dressing change, and PRN pain medication was administered as per orders. We took down the old dressing, which included a Mepilex sacral foam dressing. External male catheter in place. The sacrum and buttocks were cleansed with Sage wipes, with care to remove small amount of stool and large amount of Desitin barrier cream to region. Mineral oil also utilized to remove excess Desitin cream. Vashe wound cleanser via bulb syringe used to cleanse wounds.

We proceeded to take detailed measurements of the wound, and noted tissue, exudate, and peri-wound characteristics. There were two pressure injuries in the region. The first wound was over the midline sacrum and measured 2.0 cm x 1.2cm x 0.2cm. Wound bed moist, with reticular dermis visible to the central aspect of the wound. Epithelialization present to outer edges of the wound. The second wound was in the left upper buttock region and measured 0.8 x 0.8 x 0.2cm. Wound bed moist, with reticular dermis visible to the central aspect of the wound. Epithelialization present to outer edges of the wound. For both wounds there was scant serous drainage and no foul odors present. No adipose tissue, muscle, tendon, or bone visible. Peri-wound skin appears friable with blanchable erythema. Both wounds are stage 2 pressure injuries, as there is no evidence of full thickness injury. Medical photographs uploaded to chart.

Cavillon No String Barrier Film applied to friable peri-wound. Sacral Mepilex applied to the pressure injuries, and the dressing was dated and signed. Cavilon Durable Barrier Cream (dimethicone) applied to perinium/buttocks due to chronic incontinence and risk for IAD. Patient tolerated dressing change, with a Behavioral Pain Scale value of 4 at 09:05 AM. Discussed plan for nursing dressing changes every 72 hours (about 3 days) or as needed due to soiling. Braden Score re-evaluated as a 7 (very high risk). Discussed wound care, turn schedule, incontinence care, and nutrition consult with Sarah Smith, RN and Dr. Jones, MD. Wound care will evaluate weekly or as needed for any concerns.

WOC Plan of Care (include specific products used)

- RN Dressing Change Instructions: Cleanse perineal region with Medline Antibacterial Bathing Cloths. Remove old Mepilex dressing. Utilize Vashe wound cleanser via bulb syringe to cleanse wounds. Pat dry with sterile gauze. Apply Cavilon No Sting Barrier Film to peri-wound region. Apply Mepilex Sacral dressing so it covers both wounds.

- Check for incontinence associated moisture every 2 hours with turn schedule.

- Incontinence Care: Apply Cavilon Durable Barrier Cream to perineal/buttocks region after thoroughly cleansing with Sage wipes after each episode of stooling. Monitor external urine catheter for leakage or skin breakdown.

- Dressing to be changed every 72 hours (about 3 days) by nursing staff, or as needed due to soiling.

- Pain management: Pre-medicate per order 30 minutes prior to scheduled wound dressing change.

- Continue turn schedule and low air loss/redistribution surfaces.

- Nutrition consult for enteral or parenteral nutrition as appropriate.

- Social Work consult due to housing insecurity and inconsistent ability to obtain oxygen therapy.

- Call the WOC Team with questions or concerns regarding wound.

Describe your thoughts related to the information provided. What would you have done differently? Any additional information that would have been helpful?

1) Braden Scale: There is no documentation of a review of the bedside RN's Braden Scale scoring. When considering that he is intubated/sedated, cachexic, and NPO (no other initiations in assessment), he is at extremely high risk. In performing the Braden scale scoring, I found the following information to be accurate with the information provided:
    a. Sensory Perception: Completely Limited (1)
    b. Moisture: Often Moist (2)
    c. Activity: Bedfast (1)
    d. Mobility: Completely Immobile (1)
    e. Nutrition: Very Poor (1)
    f. Friction and Sheer: Problem (1)
    g. Total: 7 Very High Risk

2) Pressure Injury Scoring: The bedside RN documented a stage 3 pressure injury, but there is no data from the wound care provider (in the assessment section provided) regarding their interpretation of the pressure injury. A stage 3 pressure injury is full-thickness and has visible adipose tissue. Stage 3 pressure injuries often contain slough or eschar. The wound description in the assessment section does not mention slough but does mention that the reticular dermis is visible. This yellow/tan layer can resemble slough. As we only have a picture and cannot physically evaluate the wound, it is difficult to determine if this is in fact the reticular layer, but for the sake of the exercise I have assumed that the assessment is correct. A stage 2 pressure injury involves the dermis (including the reticular dermis) and does not have visible adipose tissue. There is also no evidence of granulation tissue, which is seen in stage 3 and 4 injuries.

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Goals.

What was your goal for choosing this case?

At my clinical rotation, I did see several pressure injuries, but I had not yet had the opportunity to explore assessment and treatment options in a written case study. My goal was to evaluate a pressure injury and assign the appropriate stage and treatment intervention. This goal was accomplished through this exercise. I was able to take the information provided and utilize my knowledge of pressure injury stating to determine the extent of this injury. The only pitfall to this exercise was the inability to assess this wound in person, to ultimately determine if the yellow/tan tissue in the picture is in fact the reticular dermis or perhaps slough. This would change the staging from a 2 to a 3, although the bedside interventions would not be altered.

Reviewed by: _____ Date: _____