



VS: Temperature: 99, Pulse: 92, Respirations: 26  
Initial interview: unable to obtain as patient is groggy

Braden Score: from AM by nursing staff

Sensory Perception	4
Moisture	3
Activity	1
Mobility	3
Nutrition	2
Friction/Shear	2
Total	15

**Skin breakdown assessment:**

Location: buttocks & inner thighs. Buttocks and pads soiled with liquid stool brown/yellow, reported to be constantly oozing stool

Skin breakdown type: MASD

Extent of tissue loss: superficial

Size & shape: Scattered raised papules on perianal area, with satellite lesions.

Wound bed tissue: pink

Exudate amount, odor, consistency: None

Undermining/tunneling: None

Edges: Attached

Periwound skin: non-blanchable erythema to buttocks & thighs

Pain: Not able to rate but grimaced on cleansing and pain apparent by patient comments

Rectal vault assessment: Moderate rectal tone noted and no stool obstruction.

Occasional urinary incontinence

Education: Collaborate with physician regarding drug use, liver involvement, life style

Suggested consults: identify in note

**Photo:**



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Using critical evaluation of the provided encounter data, identify what would you have done differently regarding assessment data collected, treatment recommendations, and education?

**1. Identify what would you have done differently regarding assessment data collected, treatment recommendations, and education?**

For this patient, I would have like to have seen more documentation on what the skin looked like on admission. It states the patient was down for unknown amount of time. Also, patient initial Braden Score was 8 – so I would have liked to know what initial measures were taken to prevent pressure injuries and skin breakdown. Patient should have been placed on a specialty surface. Patient does not sound like he would have been appropriate for education at any point yet. Recommendations would have included frequent assessments of FMS placement and appropriateness for continued use and at minimum the skin should have been assessed every shift. WOC nurse should have been consulted as soon as breakdown was noted. I would have also obtained a fecal sample due to the consistency and continued output of stool over the extended length of time to rule out C.Diff.

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)**

Assess rectum for any signs of rectal trauma  
Reinsert new FMS – ensuring correct placement and balloon inflation  
Stool sample to rule out C.Diff  
Assess FMS system every 2 hours with repositioning to ensure tubing is not kinked and patient is not laying on tubing.  
Dieticians consult for fluid and dietary recommendation to avoid dehydration given ongoing loose stool

Wound care to buttocks and inner thighs: BID

- 1) Gently cleanse skin with no-rinse cleanser wipes
- 2) Apply antifungal powder to wet area with satellite lesions
- 3) Apply barrier cream to affected area

Specialty low air loss surface  
External male catheter application for containment of occasional urine incontinence  
Q2 hour turn and reposition with positioning wedges

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:**

Patient being seen for skin breakdown to perineum and expelled FMS. Patient is 32 y.o. male who was admitted after being found down at home for unknown amount of time. Admission was 15 days prior and patient had stay in ICU prior to transfer to med-surg unit. Patient with frequent loose stools since

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admission and now presents with MASD to buttocks and inner thighs. Patient alert and oriented to name, follows commands but unable to provide any history at this time. Patient turned for assessment. Buttocks and inner thighs are moist, with erythema and superficial tissue loss, raised papules and satellite lesions noted to inner buttocks. Periwound is erythematous and nonblanchable. Area gently cleansed with no-rinse cleansing wipes and under pad changed. New FMS system applied and balloon inflated, ensured correct placement and tubing is unkinked and secured. Antifungal powder lightly applied to affected area on buttocks and inner thighs and excess dusted off. Barrier cream applied over powder. Patient repositioned and offloaded with positioning wedges. External male catheter applied at this time as well to assist with collection of urinary incontinence.

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?**

Goal was to address a patient with MASD – have a lot of patients with similar breakdown at my current place of employment and wanted to ensure knowledge is correct on possible treatments and care.

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

<b>CRITICAL ELEMENTS</b>	<b>Completed</b>	<b>Missing</b>
Medical record note reflects that of a specialist:		
<ul style="list-style-type: none"> <li>Identifies why the patient is being seen</li> </ul>		
<ul style="list-style-type: none"> <li>Describes the encounter including assessment, interactions, any actions, education provided and responses</li> </ul>		
<ul style="list-style-type: none"> <li>Includes pertinent PMH, HPI, current medications and labs</li> </ul>		
<ul style="list-style-type: none"> <li>Identifies specific products utilized/recommended for use</li> </ul>		
<ul style="list-style-type: none"> <li>Identifies overall recommendations/plan</li> </ul>		
Plan of Care Development:		
<ul style="list-style-type: none"> <li>POC is focused and holistic</li> </ul>		
<ul style="list-style-type: none"> <li>WOC nursing concerns and medical conditions, co-morbidities are incorporated</li> </ul>		
<ul style="list-style-type: none"> <li>Statements direct care of the patient in the absence of the WOC nurse</li> </ul>		
<ul style="list-style-type: none"> <li>Directives are written as nursing orders</li> </ul>		
Thoughts Related to Visit:		
<ul style="list-style-type: none"> <li>Critical thinking utilized to reflect on patient encounter</li> </ul>		
<ul style="list-style-type: none"> <li>Identifies alternatives/what would have done differently</li> </ul>		
Learning goal identified		