WoundAlly

Progress Note

Phone: (123) 456-7890 | Site: https://woundally.com

Email: info@woundally.com

Date of Service: **05/16/2024**

Progress Note ID: **PN-000-000-278**

Patient Name: **Green, John**
Gender: **Male**
Date of Birth / Age: **02/01/1951 73 y.o.**
Place of Service: **Home (12)**
Address: **123 Apple Sst, #10, New Hall, CA, 91321**

Patient ID: **WAT-2022-12-00048-29**
Visit Type: **Further Evaluation**
Service(s): **Wound Evaluation & Treatment, Gastrostomy Tube**
Rendering Provider: Apple, John **MD**
Referring Physician: Cherry, **Smith MD**

Chief Complaint

Consulted for skin graft application; Consulted for UltraMIST Therapy; Consulted for managing wound(s); Consulted for replacement of Gastrostomy tube.

History of Present Illness

Diabetic Status: **NIDDM Controlled**
Ambulatory Status: **Wheelchair**
Level of consciousness (LOC): **Alert**
Nutrition: **G-Tube**

Focused HPI: **73 years old male paraplegic patient with pertinent medial history of Type 2 Diabetes Mellitus, PVD, COPD with multiple chronic ulcers that has been present for more than 6 months with no progress even with advanced surgical dressings. No evidence of clinical infection; Consulted today for managing wounds and feeding tube replacement; Over the course of the patient's care, the wound has failed to achieve 50% closure. As a result of poor wound progression, it is recommended that we seek alternative measures of care to facilitate wound healing. Today the patient is starting a 10-week course of amniotic tissue to help facilitate wound closure; Wound evaluated; without infection. Wound bed prepared; dose 1 of skin substitute delivered. Follow-up in 1 week**

Medical History

Current/Past Medical History/Conditions: **I09.0 - Rheumatic myocarditis; L89.000 - Pressure ulcer of unspecified elbow, unstageable; I79.0 - Aneurysm of aorta in diseases classified elsewhere.**
Current Medications: **See Plan of Care.**

Allergy: **no any ajas.**

Social History

Alcohol Use Per Week: **0 shot(s) of strong alcohol. 0 glass(es) of wine. 0 can(s) of beer**
Substance Abuse:

Smoking History: **Unable To Obtain Information**

Support Equipment

Constitutional

Height: ***Refer to Patient's Chart**
Weight: ***Refer to Patient's Chart**
Body Mass Index: **0**

Pulse: **WNL**
Temp: **WNL**
Respiration: **WNL**

Skin Exam

Site 004 (Initial Wound Assessment)
Left, Buttock

Site 001 (Current Wound)
Left Above Malleolus, Ankle

Site 005 (Initial Wound Assessment)
LUQ, Abdomen

Site 003 (Initial Wound Assessment)
Sacrococcyx, Sacral Region

Back: **Normal**; Hip: **Normal**; Leg: **Normal**; Foot: **Normal**; Head: **Normal**; Pelvis Region: **Normal**; Chest: **Normal**; Breast: **Normal**; Ear: **Normal**; Arm: **Normal**; Spine: **Normal**; Neck: **Normal**; Face: **Normal**.

See Wound Assessment

Patient Assessment

Removal Of Slough; Weekly Debridement To Promote Healing Is Initiated; Facilitate Skin Substitute Graft; Patient Is Tolerating Gentle Sharp Debridement(s).

Additional Information

The patient's consent to the procedure has been obtained.

Wound Assessment

Wound Procedures

Site 004

Anatomical Location: **Left, Buttock**
Etiology: **Pressure Ulcer Stage 2**
Pre Debridement Measurement (LxWxD): **2.0 x 2.0 x 0.1 cm**
Wound Bed: **0% Slough / 0% Necrotic / 0% Granulation / 100% Epithelial Tissue**
Square / Volume: **4.0 cm^2 / 0.4 cm^3**
The pain level: **Pain Free (0)**
Undermining: **_**
Tunneling: **_**
Wound Assessment Parameters: **Odor (None); Exudate Amount (Minimal)**
Infection: **None**
Exudate Type: **Serous**
Periwound Skin: **Intact; Fragile**
Wound Edge: **Epithelializing**
Wound Description: **.**

Treatment Start Date: **05/16/2024**
Procedure: **Selective Debridement (SD)**
Depth of Tissue Destruction: **Partial Thickness**
Post Debridement Measurement (LxWxD): **2.0 x 2.0 x 0.2 cm**
Square: **4.0 cm^2**
Volume: **0.8 cm^3**
Pain level during the procedure: **Pain Free (0)**
Anesthesia: **4% Lidocaine Spray**
Nature of Tissue Removed: **Devitalized epidermis and dermis**
Debridement Instrument(s): **Curette**
Pain level after the procedure: **Pain Free (0)**
Procedure Description: The patient was positioned in the usual manner. Selective Debridement was performed at the bedside to remove devitalized tissue. The procedure was tolerated well. The dressing was applied as ordered.

Treatment Plan: Cleanse with Sterile Normal Saline. Pat dry. Apply . Dress with Xeroform , cover with Bordered gauze dressing , . Change dressing every 2 days and PRN for loss of integrity/Soiling.

Site 001

Anatomical Location: **Left Above Malleolus, Ankle**
Etiology: **Arterial Ulcer with necrosis of muscle**
Pre Debridement Measurement (LxWxD): **3.5 x 3.0 x 0.2 cm**
Wound Bed: **20% Slough / 10% Necrotic / 70% Granulation / 0% Epithelial Tissue**

Treatment Start Date: **05/04/2023**
Procedure: **Excisional Debridement (ED)**
Depth of Tissue Destruction: **Full Thickness**
Post Debridement Measurement (LxWxD): **3.6 x 3.1 x 0.3 cm**

Square / Volume: **10.5 cm^2 / 2.1 cm^3**
The pain level: **Pain Free (0)**
Undermining: **_**
Tunneling: **_**
Wound Assessment Parameters: **Odor (None); Exudate Amount (Moderate)**
Infection: **None**
Exudate Type: **Serous**
Periwound Skin: **Intact; Fragile; Erythema (Mild)**
Wound Edge: **Rolled; Calloused**

Wound Description: **no palpable pedal pulses.**

Square: **11.16 cm^2**
Volume: **3.35 cm^3**
Pain level during the procedure: **Pain Free (0)**
Anesthesia: **4% Lidocaine Spray**
Silver Nitrate: **None**

Nature of Tissue Removed: **Muscle**
Debridement Instrument(s): **Curette; Scalpel**
Pain level after the procedure: **Pain Free (0)**
Procedure Description: The patient was positioned in the usual manner. Excisional Debridement was performed at the bedside to remove devitalized tissue to the depth described previously in the note to healthy bleeding tissue. Hemostasis was then achieved. The procedure was tolerated well.

Treatment Plan: Cleanse withSterile Wound Cleanser. Pat dry. . Fill loosely with fillerCollagen Dry Form. Dress withAlginate (Ca)Collagen sheet, cover withABD padRoll Gauze dressing, and secure withPaper tape. Change dressingevery 2 days and PRN for loss of integrity/Soiling.

Site 005

Anatomical Location: **LUQ, Abdomen**
Etiology: **Perforating granuloma annulare (G-Tube Site) (L92.0)**
Pre Debridement Measurement (LxWxD): **0.5 x 0.5 x 0.1 cm**
Wound Bed: **0% Slough / 0% Necrotic / 100% Granulation / 0% Epithelial Tissue**
Square / Volume: **0.25 cm^2 / 0.03 cm^3**
The pain level: **Pain Free (0)**
Undermining: **_**
Tunneling: **_**
Wound Assessment Parameters: **Odor (None); Exudate Amount (Minimal)**
Infection: **None**
Exudate Type: **Serous**

Periwound Skin: **Intact; Fragile**
Wound Edge: **Attached**
Wound Description: **Peristomal hypergranulation.**

Treatment Start Date: **05/16/2024**
Procedure: **Non Selective Debridement (NSD)**

Depth of Tissue Destruction: **Partial Thickness**
Post Debridement Measurement (LxWxD): **0.5 x 0.5 x 0.1 cm**

Square: **0.25 cm^2**
Volume: **0.03 cm^3**
Pain level during the procedure: **Pain Free (0)**
Anesthesia: **4% Lidocaine Spray**
Silver Nitrate: **Applied For Hypergranulation x 1**

Pain level after the procedure: **Pain Free (0)**
Procedure Description: The patient was positioned in the usual manner. Non-Selective Debridement was performed at the bedside to remove devitalized tissue. The procedure was tolerated well. The wound was cleansed and dressing was applied as ordered.

Treatment Plan: Cleanse site with normal saline, pat dry, and apply dry dressing daily between the G-tube button and the patient's skin.

Site 003

Anatomical Location: **Sacrococcyx, Sacral Region**
Etiology: **Pressure Ulcer Stage 4**
Pre Debridement Measurement (LxWxD): **2.0 x 3.0 x 1.0 cm**
Wound Bed: **20% Slough / 0% Necrotic / 80% Granulation / 0% Epithelial Tissue**
Square / Volume: **6.0 cm^2 / 6.0 cm^3**
The pain level: **Pain Free (0)**
Undermining: **1.0-3.0 cm @ 12-6 o'clock**
Tunneling: **_**

Treatment Start Date: **05/16/2024**
Procedure: **Skin Graft (SG)**
Depth of Tissue Destruction: **Full Thickness**
Post Debridement Measurement (LxWxD): **2.1 x 3.1 x 1.1 cm**

Square: **6.51 cm^2**
Volume: **7.16 cm^3**
Pain level during the procedure: **Pain Free (0)**
Pain level after the procedure: **Pain Free (0)**

Wound Assessment Parameters: **Odor (None); Exudate Amount (Moderate)**

Procedure Description: Attention was directed to the ulcer on sacrococcyx. A sterile prep of the area was performed. A curette was utilized for sharp debridement to remove a small amount of nonviable tissue from the wound bed. After this light debridement, the ulcer bed was free of any necrotic tissue, debris, or exudate and ready to receive the graft. Hemostasis was obtained with pressure.The graft was prepared as directed by the package insert. The graft was applied to the wound bed. There was no excess graft that was trimmed away or discarded. A total of 6 sq cm of graft was used to cover the wound bed and partially overlapped onto health wound margins. The entire graft was utilized and none was discarded . The graft was fixed in place with steristrips and Calcium Alginate, then covered by a dry sterile dressing.We discussed the importance of offloading and the role it plays in healing and protecting this graft.The patient and caregivers were asked to follow up next week. The patient was told to keep this bandage clean, dry, and intact and to watch for any redness, heat, or swelling around the bandage. Asked the patient/caregivers to contact us right away if any of these are seen. Also asked the patient/caregivers to let us know right away if they experience any nausea, vomiting, fever, or chills. We reviewed the importance of glycemic control and nutrition and the role they play in protecting this graft and optimizing chances of success.SkinSub2 2x3 Lot No 12345678.

Infection: **None**

Exudate Type: **Serous**

Periwound Skin: **Intact; Fragile**

Wound Edge: **Non-attached; Rolled**

Wound Description: **.**

Treatment Plan: DO NOT REMOVE MEMBRANE AND STERI STRIPS. MAY REMOVE CALCIUM ALGINATE AND DRY STERILE DRESSING IF SOILED, THEN REAPPLY CALCIUM ALGINATE AND COVER DRY STERILE DRESSING. .

Other Procedure(s)

G-tube replacement with G-tube with KUB (GT): Informed consent was obtained for the replacement of the gastric feeding tube. The patient was in the supine position and the feeding pump was already stopped. After adequate anesthesia with 4% Lidocaine Spray. I confirmed that the balloon port of the old 18 Fr G-tube was completely deflated and then removed the old G-tube. The balloon port of a new Medline 18 Fr G-tube was checked and then replaced through the established tract. The balloon was filled with 10 ml water and secured with the adjustable button. Nonsurgical cleansing without debridement with saline moistened gauze was performed. Silver nitrate was applied for hypergranulation tissue 1 stick. A dry dressing was placed between the patient's skin and the G-tube button. 3 ml of tap water or normal saline was instilled and aspirated to verify gastric contents. Further, 20 ml gastrograffin was instilled, and KUB X-Ray was performed. Final report from Radiologist to follow. The procedure was well-tolerated without complications.G-Tube Recommendation: Cleanse the site with normal saline, pat dry, and apply dry dressing daily between the G-tube button and the patient's skin.

Encounter Complexity

Physical Examination: **Problem Focused**

Medical Decision Making: **Moderate**

Assessment

Chronic comorbid conditions: **Wound incidence is unavoidable due to Advanced Age; Diabetes; Fragile skin; Friction; Immobility or limited mobility; Multiple System Failure; Urinary or fecal incontinence; Vascular Factor; Gastrostomy Tube; HOB Elevation; Integumentary Failure; COPD; Prealbumin <14.0 g/dl.**

Staging care due to: **Poor Wound Progression; Vascular Insufficiency.**

Recommendations

Aggressive offloading, recommend: **Low air loss mattress; Frequent diaper checks and changes; Every 2 hours turning; No sitting beyond 2 hours; Offload heels on pillows**

Dietary recommendations for wound healing: **Refer to PCP Recommendations; Vitamin A, C, Zinc and Multivitamins; Pro-stat sugar free**

Additional Recommendations: **Turn patient every two hours, keep the skin clean and dry, avoid massaging bony prominences, provide adequate intake of protein and calories, maintain the current level of activity, mobility, and range of motion, use positioning devices to prevent prolonged pressure bony prominences, keep the head of the bed as low as possible to reduce risk of shearing, and keep sheets dry and wrinkle-free. Please remove all products with fragrance, including body washes and lotions. Family and patients were instructed to order diaper wipes without fragrance; ideally, the patient should use chemical-free, fragrance-free disposable washcloths**

Recommendation: **See Wound Procedures**

Diagnostic Tests

KUB Xray with Constrast to confirm feeding tube placement.

Wound Evaluation & Treatment

The conclusion of the Rendering Provider: **Current wound(s) will be revaluated in 7 days on May 23, 2024**

Date of Next Visit: **05/23/2024**

Gastrostomy Tube

The conclusion of the Rendering Provider: **We will sign-off this patient. G-tube replaced/removal, please re-consult as needed.**

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Rendering Provider: Apple, John MD

Send to: **Arton Healthcare System** Fax number: **+1 (630) 541-3353**