PALLIATIVE WOUND CARE: BALANCING THE BURDENS & BENEFITS FOR PATIENTS ON HOSPICE CARE

Pamela Scarborough
PT, DPT, CDE, CWS, CEEAA
Director of Public Policy and Education
America Medical Technologies

Disclaimer
The information presented herein is provided for educational and informational purposes only and to promote the safe-and-effective use of the wound care products provided. It is for the attendees’ general knowledge and is not a substitute for legal or medical advice. Although every effort has been made to provide accurate information herein, laws change frequently and vary from state to state. The material provided herein is not comprehensive for all legal and medical developments and may contain errors or omissions. If you need advice regarding a specific medical or legal situation, please consult a medical or legal professional. Gordian Medical, Inc. dba American Medical Technologies shall not be liable for any errors or omissions in this information.
• This program will discuss ideas and treatments for preventing pressure injuries in patients/residents on palliative/hospice care.
• In addition, the presentation will review appropriate goals and interventions for palliative wound care for patients who are receiving hospice care.

Article Available for You
Guidelines for Wound Management in Palliative Care
• Basic wound care article.
• Contains good palliative wound care principles.
• Author out of New Zealand so some products are different than those in U.S.
• Great section on Guide to Wound Dressings for those who are not wound specialists or just starting wound care as part of their practice.
• Excellent supplement to this talk.
This Article Has Been Provided for You to Download

- White paper from the National Pressure Ulcer Advisory Panel

From the NPUAP

**Pressure Ulcers in Individuals Receiving Palliative Care: A National Pressure Ulcer Advisory Panel White Paper**

Diane K. Langemo, PhD, RN, FAAN; Joyce Black, PhD, RN, CWON, CPSN; and the National Pressure Ulcer Advisory Panel

Palliative Care

- **Affirms Life**
- **Promotes Quality of Life**
- **Treats the Person**
- **Supports the Family**
Palliative Care’s Overreaching Goal

• “Goal is MUCH MORE than comfort in dying;

• Palliative care is about living, through meticulous attention to control of pain and other symptoms, supporting emotional, spiritual, and cultural needs, and maximizing functional status.”

• Credit: Nse. Punithavathi Inbanathan

National Pressure Ulcer Advisory Panel

• “The goals of palliative wound care are comfort for the individual and limiting the impact of the wound on quality of life, without the overt intent of healing.”
Pressure Injury (PI) Risk in Individuals with Advanced or Terminal Disease

- These patients are at significant risk for pressure injury
- Stage 3 and 4 pressure injuries common
- Majority of PI in hospice occur ~2 weeks before death
- Correlates with physiological shut down of body systems 10-14 days before death

Risk Factors for Pressure Injury in Hospice Patients

- Advanced age
  - Skin drier, fragile, easily injured
  - Thinner skin more vulnerable to pressure injury
- Protein-calorie malnutrition
  - 50-85% of older individuals in LTC
  - Lean body mass decreased; associated with PI development
  - Catabolism common in older patient group
  - Unintentional weight loss increases risk of developing PI by 147%
Wounds at Life’s End

- Affect up to 35% of patients at life’s end

- ~ 50% of these wounds are pressure injuries

- ~ 20% are ischemic wounds (PAD)

Wounds at Life’s End (con’t.)

- ~ 30% mixture of various wound etiologies
  - Malignant fungating wounds
  - Fistulae
  - Radiotherapy skin reactions
  - Surgical wounds turned to chronic wounds
  - Venous insufficiency/lymphedema
  - Diabetic neuropathic wounds
  - Skin tears
  - ~ 2 million patients in hospice care
  - Approximately 700,000 people need palliative wound care each year
End of Life Considerations

- May involve short periods of overwhelming illness (acute)
- Or slow deterioration lasting months to years (chronic)
- In both cases, the skin becomes particularly vulnerable to breakdown

- Witkowski and Parish concluded that skin breakdown is often unavoidable at this point

Wound Care at Life’s End

- May be component of palliative care
- Focus on alleviating symptoms
  - Pain
  - Wound odor
  - Exudate control
- If not addressed adequately, can lessen quality of life even more
Prolonging Life

- Medical technologies & life-sustaining interventions common
- Sustain life often beyond ability of skin to maintain its integrity
- Skin failure & pressure injuries in older adults & the terminally ill is not always preventable!!!
- May lead to what is termed:
  ✓ “Permissible Pressure Ulcer”
  ✓ “Skin failure”
  ✓ “Unavoidable Pressure Ulcer”
  ✓ “Kennedy Terminal Ulcer”

Skin Changes at Life’s End Scale & The Kennedy Terminal Ulcer within the Concept of Palliative Care

Pamela Scarborough
PT, DPT, MS, CDE, CWS, CEEAA
Director of Public Policy & Education
American Medical Technologies
Background

Organ dysfunction

• Acute critical illness
• Trauma
• At life’s end

Organ shut down

• Injury / interference with systems
• May lead to death

SKIN:
Decreased ability to utilize nutrients to sustain normal function

S.C.A.L.E.

• Skin Changes At Life’s End
• Expert panel published paper in 2008
• Current understanding of complex skin changes at life’s end limited

What we do know:
“Not all pressure ulcers are avoidable”
Conclusions from SCALE Expert Panel

Current Understanding Phenomenon Limited

Additional Research Needed

Observable Skin Changes At Life's End

Better Education: Clinicians, Laypeople, Policy Makers

Copyright © 2016 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com

Skin Barrier Failure

- Largest organ
- Fails like other organs
- Acute, chronic, or end-stage skin failure

Copyright © 2016 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com
Skin breakdown inevitable for some
Healing often not be realistic goal
New pressure ulcers may occur in this venerable population
Intervention in accordance with individuals wishes

NPUAP supports concept of unavoidable pressure injury in the context of multisystem organ failure in pts receiving palliative care

Robust section on prevention and treatment of pressure injuries in patients receiving palliative care

Aging Changes Skin

- 80% of adults older than 65 suffer one or more chronic conditions
- Drug therapies contribute to fragility of skin
- Advanced age, comorbidities, medications, environmental factors and lifestyle contribute to overall condition of skin
- Making skin unable to tolerate the collective magnitude of insults at life’s end
- Outcome=Skin Failure
Skin Deterioration

- In the failing individual, skin deterioration is often the most outward manifestation of overall faltering physiology

- Jane Fore, MD

Skin Failure

Langemo and Brown define “skin failure” as:

- an event in which the skin and underlying tissue die due to hypoperfusion that occurs concurrent with severe dysfunction or failure of the organ systems.
Multiple Organ Failure and Skin Failure

Multiple/Multi-Organ Failure (MOF) is considered a terminal stage of many diseases that occur as the body wastes away...

Organ Failure Stratification

- **Acute**
- **End-Stage**
- **Chronic**

**Skin Barrier Failure**
Acute Skin Failure

- Hypoperfusion to skin & underlying tissue
- Concurrent with critical illness
- ICU/Acute care setting

Chronic Skin Failure

- Hypoperfusion concurrent with **ongoing, chronic disease states**
- Occurs in a more steady fashion
- Usually older with multiple co-morbidities

Internal organ systems increasingly & irreversibly lose their ability to function as the end of life nears
Chronic Skin Failure

- Chronic illness
- Older population
- Multiple co-morbidities
- Decline in mentation & function
- Malnutrition

- Loss of fat & muscle mass
- Decreased mobility
- Skin & underlying tissue changes

End-Stage Organ Decompensation & Failure

- Large and unusual presentations of skin failure
- Body shunts blood to vital organs
- Widespread & deep tissue destruction over stressed areas can appear in a matter of hours
  - Sacrum
  - Heels
  - Posterior calf muscles
  - Arms
  - Elbows
End-Stage Skin Failure

- Skin and underlying tissue die due to hypoperfusion concurrent with end of life
- Challenges to maintaining skin integrity
- Transition from acute to chronic to end-stage - not easily observable continuum

Kennedy or End of Life Wounds

- Large ulcers in a butterfly or pear shape
- Rapid onset
- Progresses to full thickness wounds
- Often precursor to multi-organ failure
- End of life ulcer
- Exact cause unknown
- Usually appear 2-6 weeks before death
Avoidable vs. Unavoidable Pressure Ulcers

- It is important to consider that the skin is a major organ and can fail just as other organs of the body fail (e.g., heart, kidney, liver failure)

- The unavoidable pressure ulcer has been defined by CMS as a category of wound that is not preventable due to the resident’s fragile and declining physical condition, such as when there is multi-system organ failure or end-of-life conditions

CMS: Considered to be an Unavoidable Pressure Ulcers in the LTC Setting F314

- Resident developed a pressure ulcer even though the facility:
  - Evaluated the resident’s clinical condition and risk factors
  - Defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice
  - Monitored and evaluated the impact of the interventions
  - Revised interventions as appropriate
Practical Pointers
Care of Fragile Skin

- Avoid soap
- Use a pH-balanced cleanser
- Apply moisturizers
- Organic coconut oil
- Apply a moisture barrier
- Protect skin from incontinence
- Clean skin very well after bouts of incontinence
- Particularly feces
INTERVENTIONS to Mitigate Chronic Skin Failure

Well documented multidisciplinary interventions:
- Nutritional support
- Hydration
- Medical management
- Skin hygiene
- Functional rehabilitation
- Pressure redistributing surface selection

Pressure Distribution

• Reposition and turn the individual at periodic intervals, in accordance with the individual’s wishes, comfort and tolerance.
• Strength of Evidence = C
• Strength of Recommendation = 😊😊
Repositioning & Early Mobilization for Individuals Receiving Palliative Care (con’t.)

- Strive to reposition individual receiving palliative care at least every 4 hours on a pressure redistributing mattress such as viscoelastic foam, or every 2 hours on a regular mattress.
  SoE= B; SoR = 

- Document turning and repositioning, as well as the factors influencing these decisions (e.g., individual wishes or medical needs).
  (SoE=C; SoR = )

Repositioning and Early Mobilization for Individuals Receiving Palliative Care

- Pre-medicate the individual 20 to 30 minutes prior to a scheduled position change for individuals who experience significant pain on movement. (SoE=C; SoR= )

- Consider the individual’s choices in turning, including whether she/he has a position of comfort, after explaining the rationale for turning. (SoE=C; SoR= )

- Consider changing the support surface to improve pressure redistribution and comfort. (SoE = C; SoR = )
Nutrition and Hydration

- Strive to maintain adequate nutrition and hydration compatible with the individual’s condition and wishes.
- **Adequate nutritional support is often not attainable when the individual is unable or refuses to eat, based on certain disease states. (SoE = C; SoR = 📈)**
- **Offer nutritional protein supplements when ulcer healing is the goal. (SoE = C; SoR = 📈)**
Clinicians should strive to distinguish:

<table>
<thead>
<tr>
<th>Healable Wounds</th>
<th>Maintenance Wounds</th>
<th>Nonhealable Wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Have adequate blood supply</td>
<td>• Healing potential</td>
<td>• Includes palliative wounds</td>
</tr>
<tr>
<td>• Can heal if underlying causes addressed</td>
<td>• Patient/resident or health system barriers compromising healing</td>
<td>• Cannot heal due to irreversible causes/illnesses</td>
</tr>
<tr>
<td></td>
<td>• Patient/residents may be nonadherent to treatment</td>
<td>• Critical ischemia</td>
</tr>
<tr>
<td></td>
<td>• Patients/residents may have resource limitations</td>
<td>• Non treatable malignancy</td>
</tr>
</tbody>
</table>

- Wound on many people at life’s end heal
- Please give them a chance
- Prevent the increased quality of life decline that chronic wounds bring
1. Focus on Preventing and Relieving Suffering

- Focused on preventing and relieving suffering of the individual with life-threatening illness and his or her significant others through:
  - Identification, assessment and relief of distressing physical, psychosocial and spiritual issues, and pain while neither hastening nor prolonging death
2. Goals of care

- Goals of care should be established in collaboration with the individual and his or her significant others.
- To the extent possible, allow the individual to direct care.

Goals for Palliative Wound Care

- Prevent wound from getting larger
- Prevent new pressure injuries
- Prevent infection
- Manage odor & exudate
- Assess & treat pain/discomfort
3. NOT Lack of Care

- Palliative pressure ulcer care is not ‘lack of care’, but care focus on **comfort and limiting the extent or impact of the wound**
- Prevention of new pressure ulcers remains important; however, during the period of active dying, **comfort and/or the individual’s preference may override implementation of active prevention strategies.**

General Principles for Pressure Ulcer Management

- Manage and control individual’s symptoms
- Promote best quality of life
- Neither hasten nor prolong death process
- Collaborative goals for care with individual & family
- Where possible allow individual to direct care
- Focus on comfort
- Limit impact of wound on quality of life
- Implement current wound care interventions that meet the standards of care with caveats for palliative/hospice care (e.g. Dakin's solution for longer than 2-3 days)
Practical Pointers

- Encourage turning & repositioning to the extent possible
- Protect heels
- Assess treat, reassess wound associated pain
  - Medications
  - Appropriate wound care
  - Nonadherent dressings
  - Skin sealants
  - Nonpharmacologic techniques
Palliative Care
When Healing is NOT the Goal

- Individual receiving palliative care whose body systems are shutting down often lacks the physiological resources necessary for complete healing of the pressure ulcer.
- As such, the goal of care may be to maintain or improve the status of the pressure ulcer rather than heal it.

Treatment Goals for Palliative Care

- Set treatment goals consistent with the values and goals of the individual, while considering input from the individual’s significant others.
- SoE = C;
- SoR = ★★
Treatment Goals (con’t)

• Set a goal to enhance quality of life, even if the pressure ulcer cannot be healed or treatment does not lead to closure/healing.
  • SoE = C; SoR = 🔳

• Assess the individual initially and at any change in their condition to re-evaluate the plan of care.
  • SoE = C; SoR = 🔳

Pressure Ulcer Assessment in Palliative Care

• Assess the pressure ulcer initially and with each dressing change, but at least weekly (unless death is imminent), and document findings.
  • SoE = C; SoR = 🔳

• Monitor the pressure ulcer in order to continue to meet the goals of comfort and reduction in wound pain, addressing wound symptoms that impact quality of life such as malodor and exudate.
  • SoE = C; SoR = 🔳
Control Wound Odor

• Manage malodor through:
  – regular wound cleansing;
  – assessment & management of infection;
  – debridement of devitalized tissue,
  – consider the individual’s wishes and goals of care
  – SoE = C; SoR = ✴✴

• Consider use of topical metronidazole to effectively control pressure ulcer odor associated with anaerobic bacteria and protozoal infections (SoE = C; SoR = ✴✴)

• Consider use of charcoal or activated charcoal dressings to help control odor. (SoE = C; SoR = ✴✴)

• Consider use of external odor absorbers or odor maskers for the room (e.g., activated charcoal, kitty litter, vinegar, vanilla, coffee beans, burning candle, and potpourri). (SoE = C; SoR = ✴✴)

• Pamela addition = Essential oils utilizing diffuser

Pain Assessment and Management

• Do not under treat pain in individuals receiving palliative care.
  – SoE = C; SoR = ✴✴

• Select a wound dressing that requires less frequent changing and is less likely to cause pain.
  – SoE = C; SoR = ✴✴
Patient and Risk Assessment

- Complete a comprehensive assessment of the individual.
  - SoE = C; SoR = 😊😊
- Consider using the Marie Curie Centre Hunters Hill Risk Assessment Tool, specific to adult individuals in palliative care.
  - SoE = C; SoR = 😊

Complementary Therapies

- May be of benefit in management of wound pain
- Include:
  - Relaxation techniques
    - Music
    - Reading to patient
    - Breathing
  - Massage
  - Visualization
  - Imagery
  - Distraction
- These techniques help in reduce pain or pain response by breaking the anxiety-pain cycle

Copyright © 2016 Gordian Medical, Inc. dba American Medical Technologies. www.amtwoundcare.com
Closing Thoughts

- Limited studies on wounds at life’s end
- Prevalence ~ 1-million hospice patients
- Millions of frail elderly
- More coming
- Awareness of risks for pressure injury
- Develop as robust wound prevention and care program as possible

References

- http://www.aoa.gov
- http://www.agingstats.gov
- http://www.frailcare.org/
- http://npuap.org
- Reddy M. Skin and Wound Care: Important Considerations in the Older Adult: Advances in Skin & Wound Care, Vol 21, No 9-424-438, 2008.
References

- Tippett, AW; Wounds at the End of Life; Wounds. 2005; 17(4):91-98 HMP Communications.