Exploring the Path of Palliative Wound Care
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Objectives
- Define Wound Stages, Arterial, Venous and Diabetic Ulcers
- Determine appropriate Wound Treatments base on the needs of the Patient
- Discuss the Kennedy Terminal Ulcer and related CMS documentation
- Recognize and Identify Team Members that can Complement Patient Care

Wound Care Products of the Past
- Mercurochrome
- Neosporin Powder
- Maalox
- Sugar
- Heat Lamps
- Montgomery Straps

Wound Care and the Palliative Patient
- Focus is Changed from What is Best for the Wound to What’s Best for the Patient
- View Patient in a Holistic Manner
- Patient should be given Control to Facilitate the Highest Level of Independence, Dignity and Comfort
- Secondary Goals may include Healing the Wound, Preventing Decline of the Wound, Preventing Infection, Managing Odor, Controlling Exudate and providing Adequate Pain Control

Stage I Pressure Ulcer
- Non–blanchable erythema in a localized area usually over a bony prominence
- Darkly pigmented skin may not have visible blanching but the color may differ from the surrounding tissue
- The tissue may be painful, firm, soft, warmer or cooler as compared to adjacent tissue
- May indicate patient is “at risk” for further skin breakdown
Stage 2 Pressure Ulcer

- Partial Thickness Skin Loss
- Presents as a Shallow Open Ulcer
- Usually has Red/Pink Wound Bed without Slough
- Can also present as an Intact or Open/Ruptured Serum-Filled Blister
- DO NOT use this Stage to describe Skin Tears, Tape Burns, Perineal Dermatitis, Maceration or Excoriation

Stage 3 Pressure Ulcer

- Full Thickness Tissue Loss
- Subcutaneous Fat may be Visible, but Bone, Tendon or Muscle are NOT Exposed
- Slough may be present but does not obscure the depth of tissue loss
- May include Undermining and Tunneling
- Depth of Ulcer Varies by Anatomical Location
- The Bridge of the Nose, Ear, Occiput and Malleolus do not have Subcutaneous Tissue and can be Shallow
- Areas of Significant Adiposity can Develop Extremely Deep Stage 3 Pressure Ulcers

Stage 4 Pressure Ulcer

- Full Thickness Tissue Loss with Exposed Bone, Tendon or Muscle
- Slough or Eschar may be present on Some Parts of the Wound Bed
- Undermining and Tunneling often present in Wound
- Depth of Ulcer Varies by Anatomical Location
- The Bridge of the Nose, Ear, Occiput and Malleolus do not have Subcutaneous Tissue and can be Shallow
- Stage 4 Pressure Ulcers can Extend into Muscle, and/or Supporting Structures (Fascia, Tendon or Joint Capsule) and Osteomyelitis is possible
Unstageable Pressure Ulcer
Depth Unknown

• Full Thickness Tissue Loss
• The Wound Base Covered by Slough is generally Yellow, Tan, Gray, Green, or Brown in Color
• The Wound Base Covered by Eschar is generally Tan, Brown or Black in Color
• Until the Slough or Eschar are Removed to Expose the Wound Base the Wound Stage cannot be determined because the True Depth is Unknown
• Stable (dry, adherent, intact without erythema or fluctuance) Eschar on the Heels Serves as “the body’s natural cover” and should not be removed

Suspected Deep Tissue Injury
Depth Unknown

• Purple or Maroon Discolored Intact Tissue or Blood Filled Blister in a Localized Area
• Usually due to Damage of Underlying Soft Tissue from Pressure and/or Shear
• The area may be Preceded by Tissue that is Painful, Firm, Mushy, Boggy and/or Warmer or Cooler as Compare to Adjacent Tissue
• May be Difficult to Detect in Patients with Dark Skin Tones
• Evolution may include a Thin Blister over a Dark Wound Bed
• This Wound may further Evolve and become a Wound Base covering of Thin Eschar
• Final Evolution of this Wound Type may be a Rapid Exposing of Additional Layers of Tissue even with Optimal Treatment

Arterial Ulcers

• Typical Locations are Tips of Toes, Corners of Nail Beds on Toes, over Boney Prominences and between Toes
• Pale or Mottled Wound
• Well-Demarcated Wound Edges
• Dry Wound Base with No Granulation Tissue
• Presence of Necrotic Tissue very common
• Surrounding Skin feels Cooler than Normal with Palpation
• Dependent Rubor
• Thin, Pale Yellow Nails that may be Thick due to Fungal Infection
• History of Claudication (pain distal to narrowed artery triggered by exercise and relieved with rest)
• Rest Pain (generally occurs when patient is asleep and resolves by lowering extremity)
Venous Ulcers

- Generally located in Gaiter Area of Leg (ankle to mid calf) and most common on Medial Aspect of Ankle above the Malleolus
- Wound is usually Irregular Shaped
- Dry, Crusted or Moist, Slightly Macerated Borders
- Shallow Wound Base with Beefy Red Granulation Tissue, Yellow Film or Gray Necrotic Tissue (black necrotic tissue usually only present in an acute injury)
- Edema (generally first sign of venous disease)

Diabetic Ulcers

- Neuropathy can cause Impaired or Loss of Function in the Tissue due to Affected Nerve Fibers that can cause Pain or Decreased Sensation
- Pressure, Friction and Shear are generally the Primary cause of Diabetic Ulcers
- Peripheral Vascular Disease is generally associated with Diabetes and can Impair Healing of Ulcers and Contribute to Neuropathy
- Autonomic Neuropathy can cause Osteopenia in the Foot and Ankle and the End Result may be Charcot Disease (fractures of the mid foot that the patient does not feel, resulting in the collapse of the mid foot and increased risk of plantar pressure ulcers)

Diabetic Foot Ulcers

- Originally termed and noted by Karen Lou Kennedy NP at Byron Health Center in Fort Wayne, IN in 1983
- Skin requires 25–33% of Cardiac Output to Maintain its Integrity
- Therefore, Unavoidable Skin Breakdown or Skin Failure occurs as part of the Dying Process
- Comes on Quickly and Often within Hours
- Usually Superficial but Grows in Depth and Size Rapidly
- Most often found in the Sacral/Coccygeal region
- Most often found in the Geriatric Population
- Typically Pear Shaped and Red/Yellow/Black in Color
- Can be Characteristic of an Early Deep Tissue Injury
- Similar in appearance to an Abrasion and Tissue is Very Fragile
- Death usually occurs in as little as 8–24 hours of Identification and these Ulcers usually Develop in the Final 2 Weeks of Life
Skin Failure

“an event in which the skin and underlying tissue die due to hypoperfusion that occurs concurrent with severe dysfunction or failure of other organ systems”

Langemo and Brown

despite prudent management of extrinsice factors such as pressure offloading and nutrition, intrinsic factors may have stronger influence on the ability to heal wounds

Thomas

Kennedy Terminal Ulcer

Skin ulcers that develop in patients who have terminal illness or are at the end of life should be assessed and staged as pressure ulcers until it is determined that the ulcer is part of the dying process (also known as Kennedy ulcers). Kennedy ulcers can develop from 6 weeks to 2 to 3 days before death. These ulcers present as pear-shaped purple areas of skin with irregular borders that are often found in the sacrococcygeal areas. When an ulcer has been determined to be a Kennedy Ulcer, it should not be coded as a pressure ulcer.

Dr. Jeffrey M. Levine MD
SeniorHealth Consulting 2011

CMS Recognizes the Kennedy Terminal Ulcer in Long –Term Care

Kennedy Terminal Ulcer

MDS and Healthcare Providers Documentation

“Because the ulcer is often a sign of death, the care plan and nursing notes can begin to reflect the resident’s or patient’s last wishes, last measures for comfort and last contacts to necessary family for preparation. This documentation can be critical during a survey process. Skin breakdown is a key measure of quality of care, it is absolutely necessary that all documentation to support inevitable skin breakdown accompanied with support that the breakdown might actually be related to the active dying process can make all the difference in how a surveyor interprets staff actions and delivery and quality of care.”

Bed–Check

The Kennedy Terminal Ulcer—a Sign to Caregivers
Wound Treatment and the Palliative Care Patient

- Provide the patient and/or family with education regarding treatment options or plan of care
- Aggressive or Palliative Care???
- Discuss the Kennedy Terminal Ulcer with Patients and Families
- Remind Patients and Families that Palliative/Comfort Care *does not mean NO CARE*

- Select Products to Disrupt the Patient as Little as Possible
- Select Dressings to Heal the Wound or Prevent Further Decline
- Dignity is Maintained when using Dressings that Help Control Odor
- If Debridement is needed for Odor Management the Preferred Method is Autolytic

Pain Management with Wound Treatment

- Anxiety due to Perceived Pain can be a True Concern for the Patient with each Dressing Change
- Utilizing Wound Contact Layers can Reduce Adherence of Dressings with Removal
- Pain Medication for both Soft Tissue Pain and Neuropathic Pain should be Utilized to Manage Pain Levels with each Dressing Change

Wound Treatment Selection for the Palliative Care Patient

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Wound Treatment Option

Transparent Films

*Action: Adhesive, semipermeable, polyurethane membrane that may vary in thickness and size. They are waterproof and impermeable to bacteria and contaminants, yet they permit water vapor to cross the barrier. These dressings maintain a moist healing environment, promoting formation of granulation tissue and autolytic debridement.*

Indication: Can be used as a primary or secondary dressing to prevent and manage Stage 1 pressure ulcers, partial-thickness wounds with little or no exudate, and wounds with necrotic tissue or slough.

Wound Treatment Option

Hydrocolloids

*Action: Occlusive or semiocclusive dressings composed of such materials as gelatin, pectin, and carboxymethylcellulose. They provide a moist healing environment that allows clean wounds to granulate and necrotic wounds to debride autolytically. They can leave residue in the wound and may adhere to the skin around the wound. Manufactured as wafers, pastes and powders.*
Wound Treatment Option
Hydrocolloids
Indication: Can be used as a primary or secondary dressing to manage select pressure ulcers, partial and fullness wounds, with necrosis or slough, and wounds with light to moderate exudate.

Wound Treatment Option
Hydrogels
Action: Water or glycerin based amorphous gels, impregnated gauze or sheet dressings. Due to their high water content, some can’t absorb large amounts of exudate. They help maintain a moist healing environment, promote granulation and epithelialization, and facilitate autolytic debridement.

Wound Treatment Option
Hydrogels
Indication: Can be used as primary dressing (amorphous and impregnated gauze) or as primary or secondary dressing (sheet). They can also manage partial and full-thickness wounds, deep wounds (amorphous, impregnated gauze), wounds with necrosis or slough, minor burns and tissue damaged by radiation.

Wound Treatment Option
Foams
Action: Nonlinting and absorbent. They vary in thickness and have non-adherent layer, allowing nontraumatic removal. Some have adhesive borders and may have a film coating as an additional bacteria barrier. Foam dressings provide a moist environment and thermal insulation. They are manufactured as pads, sheets, and pillow (cavity) dressings.

Wound Treatment Option
Foams
Indications: Foam dressings may be use as primary and secondary dressings for partial and full-thickness wounds with minimal, moderate, or heavy drainage, as primary dressing for absorption and insulation, or as secondary dressings for wounds with packing. They may also be used to absorb drainage around tubes.

Wound Treatment Option
Alginate
Action: Derived from brown seaweed. Composed of soft, nonwoven fibers shaped as ropes (twisted fibers) or pads (fibrous mats). They are absorbent and conform to the shape of a wound. When packed, an alginate interacts with wound exudate to form a soft gel that maintains a moist healing environment. This product can absorb up to 20 times its weight.
Wound Treatment Option
Alginate
Indications: Management of partial and full-thickness, draining wounds; wounds with moderate to heavy exudate; tunneling wounds; infected and noninfected wounds; and “moist” red and yellow wounds.

The TEAM
• Nursing
• Physical Therapy
• Occupational Therapy
• Recreational Therapy
• Pharmacy
• Dietician
• Social Service
• Purchasing/Central Supply Manager
• Chaplain
• Hospice Agencies

Personal Rewards

Stay Connected
• Webinar “Bioburden: The Underlying Issue”
  Thursday March 31, 2016 at 6:00PM CST
• WI/LTC Nursing Continuum Symposium 2016
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