Perspectives on Palliative Wound Management

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Palliation in Wound Care

• Assessment of the individual and his/her wounds to determine whether palliation is appropriate

• Focus shifts from traditional wound care where healing and wound closures are the goals, to promotion of comfort, dignity, and improvement in QOL
Primary Goals of Palliative Wound Management

• Stabilizing existing wounds
• Prevention of new wounds if possible
• Symptom management of complications to improve patient comfort, well-being, and quality of life
  – Prevention of infection
  – Managing exudate (drainage)
  – Controlling odor
  – Providing adequate pain control
Function of Normal Skin, Largest Body Organ

- Provides protection against microbes, physical and chemical insults
- Thermoregulation (through sweat and hair)
- Controls loss of water
- Nerve cells detect and relay changes in the environment (heat, cold, touch, and pain)
- Acts as a reservoir for the manufacture of vitamin D

• WebMD, 2014
4 Phases of wound healing

Phase 1
- Day 1 to 3
  - Hemostasis: Stop Bleeding

Phase 2
- Day 3 to 20
  - Inflammation: New frame work for blood vessel growth

Phase 3
- Week 1 to 6
  - Pulls the wound closed
  - Proliferation or Granulation

Phase 4
- Week 6 to 2 Years
  - Final proper tissue
  - Remodeling or Maturation
Recognizing the Palliative Wound

- Aging skin and skin changes at EOL
- Multiple comorbidities that impact healing
- Wound bed issues
- Nutritional deficiencies
Aging Skin and EOL Skin Changes

- Skin changes
- Kennedy Terminal Ulcer
Multiple Untreatable Comorbidities

Calciphylaxis of Renal Failure

Arterial Insufficiency

Venous Insufficiency

Diabetic Foot Ulcer
Wound Bed & Periwound Issues

Maceration

Week 0

Epibole and Granulation Tissue

Slough and Granulation Tissue

Necrotic Eschar with Slough
Nutritional Deficiencies

• Metabolic demands exceed intake
• Barriers to adequate nutrition
  – Diminished swallowing abilities
  – Anorexia
  – Dependency for feeding
  – Dysphagia
  – Pain
  – Depression

• Maintain adequate nutrition and hydration that is compatible with the individual’s condition and wishes.
Pressure Ulcers

• Definition: localized injury to the skin and/or underlying soft tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear

• Can present as intact skin or an open ulcer and may be painful

• Staging: classification according to the amount of visible tissue loss
Staging Pressure Ulcers

• Classification system not designed for use in any other wound type

• Differentiating pressure ulcers from other wound etiologies is within the domain of registered nurses.

• RNs are expected to assess the patient’s skin, stage the wound, and implement an individualized plan of care based on the patient needs.
Anatomy of Skin

Healthy Skin – Lightly Pigmented

- Epidermis
- Dermis
- Adipose
- Tendon
- Muscle
- Bone

Healthy Skin – Darkly Pigmented

- Epidermis
- Dermis
- Adipose
- Tendon
- Muscle
- Bone

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Blanchable vs Non-Blanchable

Blanchable

Non-Blanchable
Stage 1 Pressure Injury

• Non-blanchable erythema of intact skin
Stage 1 Treatment Protocol

• Barrier Cream (Peri-Guard)
• For incontinence-perineal cleanser and barrier cream
• Repositioning—Every 2 hours when in bed, every hour if up in chair
• Consider gel overlay sleep surface
Stage 2 Pressure Injury

• Partial-thickness loss of skin with exposed dermis.
Stage 2 Treatment Protocol

- Barrier cream – Calmoseptine
- If incontinent-perineal cleanser and Calmoseptine
- Protect/offload
- Gel overlay sleep surface, gel cushion in chair
- May consider low air loss mattress
Stage 3 Pressure Injury

• Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.
Stage 3 Treatment Protocol

- Cleanse with wound cleaner at every dressing change
- Protect, hydrate, and fill dead space
- If **dry**, wound gel in base, cover with appropriate size Allevyn-change Q3-4 days and prn
- If **moist**, calcium alginate, cover with appropriate size Allevyn-change Q 3-4 days and prn
- Protect wound edges from maceration-apply skin prep to peri-wound
- Low air loss mattress
Stage 4 Pressure Injury

- Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.
Stage 4 Treatment Protocol

• Cleanse with wound cleaner at every dressing change
• Protect, hydrate, and fill dead space
• If dry, wound gel in base, cover with appropriate size Allevyn-change Q3-4 days and prn
• If moist, calcium alginate, cover with appropriate size Allevyn-change Q 3-4 days and prn
• Protect wound edges from maceration-apply skin prep to peri-wound
• Low air loss mattress
Unstageable Pressure Injury

- Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.
Unstageable Treatment Protocol

- Wound gel, cover with appropriate size Allevyn-change daily and prn
- May also consider honey gel
- **Exception**- stable eschar on heels acts as a biological cover and removal of eschar is contraindicated. Keep dry, paint with betadine daily and prn, float heels.
Deep Tissue Pressure Injury

- Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.
Deep Tissue Treatment Protocol

• Education and early recognition
• Keep skin intact
• Skin prep elbows, heels, ears
• Turn and reposition
• Off load
• Low air loss mattress
Medical Device Related Pressure Injury

- This describes an etiology. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.
Medical Device Treatment Protocol

• Thorough assessment of the skin underneath and around the device

• Cushion and protect the skin with appropriate dressing selection-foam, thin hydrocolloid, barrier cream, skin prep
Mucosal Membrane Pressure Injury

- Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury.
- Due to the anatomy of the tissue these ulcers cannot be staged.
To Debride or not to Debride

- Sharp (surgical)
- Enzymatic
  - Santyl ( $$$)
- Autolytic
  - Wound gel (various brands and names)
  - Manuka Honey (Therahoney, Medihoney)
  - Cadexomer Iodine (Iodosorb)
- Mechanical
  - Wound irrigation
  - Wet to dry dressings
  - Whirlpool therapy
- Maggot therapy
What is Exudate?

• Exudate production is a normal feature of healing wounds.

• Can impair healing in chronic wounds
  – Slows down or prevents cell proliferation
  – Interferes with growth factor availability
  – Contains increased levels of protein digesting enzymes
Wound Dressing Selection

• Ability to keep the wound bed moist
• Need to address bacterial bioburden
• Nature and volume of wound exudate
• Condition of the tissue in the wound bed
• Condition of the periwound
• Ulcer size, depth and location
• Presence of tunneling/undermining
• Goals of the individual/family
Categories of Wound Dressings

- Foams
- Alginate
- Hydrofibers
- Hydrogels
- Hydrocolloids
Foam Dressings

Advantages
• Provides a warm, moist environment for healing
• Serves as a cushion to protect the wound
• Provides a barrier against infection
• Can be used for infected wounds
• Does not adhere to wounds
• Easy to apply and remove

Disadvantages
• Maceration of periwound can occur if dressing becomes saturated with exudate
• Wound may dry out if there is little or no exudate
Alginate Dressings

- Dressings with calcium and sodium fibers made from seaweed
- Spun into ropes or flat dressings
- Transforms into a moist gel coming in contact with exudate
- Absorbs up to 20 times its weight
- Some products contain silver or honey to provide antimicrobial protection
Alginate Dressings

Advantages

• Especially useful for packing exudating wounds with tunneling and undermining
• Can be used when there is clinical evidence of wound infection
• Easy to use and comfortable for the patient
• Conforms easily to wound shape

Disadvantages

• Requires a secondary dressing
• Can be too drying if the wound has low volume of exudate
• Some can leave fibers in the wound if not irrigated well
• Cannot be used for Stage IV PrU with exposed tendon or bone
• Can damage wound bed tissue if packed tightly
Hydrofiber Dressings

Advantages

• Provides moist environment

• Good choice for moderate to heavily draining wounds

• Available in various sizes including sheets and ropes

• Unique locking action makes dressings with hydrofiber technology more effective than traditional gauze or alginate dressings at retaining fluid

Disadvantages

• Non adherent so needs to be secured with a secondary dressing

• Can be too drying if there is little or no exudate
Hydrogel Dressings

Advantages
- Helps facilitate autolytic debridement
- Creates a moist healing environment promoting granulation and epithelialization
- Soothing and reduces pain
- Fills in dead space for deep wounds
- Can be used when infection is present
- Available in various forms: amorphous gel, sheets or pads

Disadvantages
- Requires a secondary dressing
- Some may be difficult to secure
- Can cause periwound maceration in heavily exudative wounds
- Can dehydrate easily if not covered
Hydrocolloid Dressings

Advantages
- Occlusive, provides moist environment
- Impermeable to bacteria, urine, stool
- Easy to apply
- May be used under venous compression products
- Dressing can be worn for several days (check manufacture’s guidelines)

Disadvantages
- Not recommended for wounds with heavy exudate or infected wounds
- Wound assessment difficult if dressing is opaque
- May curl or roll at the edges
- May cause periwound maceration
- May leave residue in the wound bed upon removal
- May cause injury/trauma to fragile wound upon removal
- Use with caution in diabetic foot ulcers
Identifying Infection

Localized infection
- Redness/warmth
- Increased pain at site
- Increase in periwound edema
- Bleeding or friable granulation tissue
- Malodor
- Sudden change in characteristics of exudate
- Pocketing/bridging

Worsening of localized infection
- Wound breakdown
- Cellulitis spreading from wound edges
- Crepitus, warmth, induration
- Fever, chills, general malaise in patient
Antimicrobial Products

- Honey
- Silver
- Cadexomer iodine
Documentation

- LPN’s cannot stage pressure ulcers, but can monitor and describe their appearance
- Skin S/S field on ICA 2015, FCA 2015, and Nursing Note 2015, under second Systems Review tab
Documentation Con’t

• The comment section of the Skin S/S field can be utilized to document treatment provided at the visit.
Physician Order

**A modified order needs to be obtained and entered into the patient’s medical record for all wound treatments, regardless of the type of wound or treatment.**

**Order should include the location of the wound, the cleaning instructions, all products used to treat the wound, and the frequency of the dressing change.**
Wound Assessment Wizard

**Utilized weekly (at minimum) by RN to document assessment of wounds**

**RN assessment includes: location, type, stage (if a pressure ulcer), length, width, depth, odor, appearance and amount of exudate, and amount of necrotic tissue**

**LPN documentation can include all of the above factors except stage and type of wound if not previously assessed by an RN**
Wound Assessment Wizard

**A more detailed description of the wound can be done by adding free text into the Result Sentence text box of the Wound Description field**

**Other Descriptions:**
- % of slough
- % of granulated tissue
- “hour” of tunneling
- appearance of edges
Plan of Care (POC)

** The patient’s POC should include a skin PIO regardless of the type of wound
** The PIO should contain the most appropriate goal and interventions that are individualized to the patient
** The PIO should be discontinued once the skin issue is resolved
** Wounds should be discussed at each IDT meeting and during SNF care plan meetings

<table>
<thead>
<tr>
<th>PIO</th>
<th>Skin/ Membrane Integrity Impaired due to Disease progression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Maintain optimal skin integrity</td>
</tr>
<tr>
<td>Interv</td>
<td>Assess skin, tissue and membrane integrity</td>
</tr>
<tr>
<td>Interv</td>
<td>Collaborate with physician and IDT re pt’s care needs</td>
</tr>
<tr>
<td>Interv</td>
<td>Coordinate with wound nurse as needed</td>
</tr>
<tr>
<td>Interv</td>
<td>Establish skin care regimen</td>
</tr>
<tr>
<td>Interv</td>
<td>Instruct in optimal mobility, positioning, and nutrition</td>
</tr>
<tr>
<td>Interv</td>
<td>Instruct in principles of maintaining skin/membrane integrity</td>
</tr>
<tr>
<td>Interv</td>
<td>Instruct in treatment and medication regimen</td>
</tr>
<tr>
<td>Interv</td>
<td>Order DME/Medication/Supplies per physician order</td>
</tr>
</tbody>
</table>
Quiz
(Please use the answer sheet provided)

1. Palliative wound management focuses on:
   A. comfort & dignity
   B. healing wounds
   C. improvement in quality of life
   D. both A and C

2. Palliative wound management goal(s) include:
   A. preventing infection
   B. managing exudate
   C. controlling odor
   D. all of the above
3. All of the following occur as skin ages except:
   A. the epidermis and dermis lose their elasticity
   B. the epidermis and dermis become thicker
   C. the sweat glands become smaller, producing less sweat
   D. the wound healing process decreases

4. All of the following are true statements except:
   A. only pressure ulcers are classified using the staging system
   B. the LPN cannot stage a wound, but can measure it and document its appearance
   C. the RN should document the wound measurements and other characteristics on the wound wizard every other week
   D. an order must be obtained for all wound care treatments that are being performed
5. The following documentation is incorrect because:

A. wounds should not be measured in centimeters (cm)
B. only pressure ulcers should be documented on the wound assessment wizard
C. only stage 3 & 4 pressure ulcers should be measured
D. a skin tear should not be staged
6. What stage is this wound:
   A. stage 1
   B. stage 2
   C. stage 3
   D. unstageable

7. All of the following describe this wound except:
   A. necrotic
   B. deep tissue injury
   C. non-blanchable
   D. intact
8. When eschar on a heel is dry, adherent, and intact it should be:
   A. debrided surgically
   B. not softened or removed
   C. debrided with Santyl
   D. debrided with a wet to dry dressing

9. If a wound shows clinical s/s of infection the hospice nurse should first:
   A. culture the wound right away
   B. treat the infection with triple antibiotic ointment
   C. notify the physician or nurse practitioner
   D. do nothing as infection in a wound is expected

10. An Allevyn dressing should be used:
    A. only if an order was obtained from the hospice physician or nurse practitioner for its use
    B. on all of a patient’s bony prominences for protection
    C. to cover a skin tear
    D. as a means for the hospice nurse to decrease the nursing visit frequency to 1x/week
11. Which of the following wounds is described as intact skin with non-blanchable redness of localized area usually over a bony prominence:
   A. possible deep tissue injury
   B. that is not considered a wound
   C. stage 4 pressure ulcer
   D. stage 1 pressure ulcer

12. The manual measurement technique which results in the least overestimation for various wound shapes is which of the following:
   A. measure at the longest and widest points in the wound, regardless of locations or orientation
   B. measure the longest length of the ulcer head-to-toe and the longest width side-to-side, perpendicular (at 90 degrees) to the length
   C. measure length at the longest part of the wound, regardless of location or orientation and width perpendicular (at 90 degrees) to length
   D. none of the above
13. Possible description of this wound includes all of the following except:
   A. location: covers greater than half of the dorsal surface of the left foot
   B. stage: unstageable
   C. edges: peri-wound maceration
   D. depth: no measureable depth

14. All of the following are debridement agents except:
   A. wound gel
   B. maggots
   C. alginate rope
   D. Therahoney
15. The correct classification of this wound is:
   A. venous ulcer
   B. stage 2 pressure ulcer
   C. stage 3 pressure ulcer
   D. diabetic ulcer
Resources

• National Pressure Ulcer Advisory Panel [http://www.npuap.org/](http://www.npuap.org/)
• Wound care companies
  – Cardinal Health
  – ConvaTec
  – Coloplast Corp.
  – Crawford Healthcare
  – Derma Science, Inc.
  – Ferris Mfg. Corp.
  – Medline Industries, Inc.
  – Molnlycke Health Care, USA
  – Smith & Nephew, Inc.
References


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