Providing Quality Wound Care at the End of Life

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Disclosures

Marilyn Graves has no real or perceived conflicts of interest that relate to this presentation.

Objectives:

1. Define palliative wound care.
2. Describe the wounds commonly seen in chronically ill, elderly and hospice care patients.
3. Describe evidence-based assessment and current management of wounds in palliative care.
4. Identify gaps in research related to palliative wound management.
Definitions

- **Palliative care** (from Latin palliare, to cloak) – an approach to improve the quality of life of patients/their families who are facing life-threatening illness (WHO, 2002)
- **Palliative wound care** – the incorporation of strategies that prioritize symptom relief and wound improvement ahead of wound healing or total closure (Alvarez, 2007)
- **Palliative wound care** – an evolving body of knowledge and skills that take a holistic approach to relieving suffering and improving quality of life for pts. and family living with chronic wound, whether the wound is healable or not (The International Palliative Wound Care Initiative, 2007)

Definitions cont’d

- “Palliative wound care is a complex concept that extends beyond the concealing of unpleasant symptoms. As a holistic and integrated approach to care, palliative wound care encompasses:
  1. Symptom management
  2. Improvement of psychosocial well-being
  3. A multidisciplinary team approach
  4. Patient/family-driven goals” (Emmons & Lachman, 2010)

What is palliative wound care? Why is it important?

- “Palliative care is not synonymous with the abandonment of hope or treatment options.” (Alvarez et al., 2002)
- “Providing effective wound care is important because the presence of a non-healing wound threatens physical health and quality of life.” (Emmons & Lachman, 2010)
What is palliative wound care?
Why is it important?

- “A wound is a very visible reminder of a patient’s illness, and declining condition and is seen as a breach in the integrity of the wholeness of a person.” (Navaid et al., 2010)
- “It is important that patient comfort take priority over preventing skin breakdown and care of the wound in palliative care.” (Langemo, 2006)

When is it indicated?
Ennis and Meneses (2005) suggest asking:

“Would this patient’s life be significantly better, from a quality-of-life stand point if the wound was healed?”

Common Wounds

- **Pressure ulcers** – unrelieved pressure resulting in damage of underlying tissue
- **Arterial ulcers** – ischemic ulcers, result of tissue ischemia due to arterial insufficiency
- **Venous ulcers** – failure of the venous valve function to return blood from the lower extremities to the heart
Common Wounds

- **Neuropathic/Diabetic ulcers** – result from damage to the autonomic, sensory/motor nerve and have an arterial perfusion deficit
- **Skin tears** – results from either a separation of the epidermis and dermis or both the epidermis and dermis from the underlying structures
- **Chronic, non-healing wounds** – Any interruption in the continuity of the skin that either requires longer than a 6 month period to heal or fails to heal

Other Wounds

- **Lymphedema** – edema due to obstruction of lymphatics
- **Suspected deep tissue injury** – purple/maroon localized area of discolored intact skin/blood-filled blister due to damage of underlying soft tissue from pressure and/or shear
- **Kennedy Terminal Ulcer** – sudden onset and usually appears about 2 weeks before death, superficial but progresses quickly in size and depth

Other Wounds

- **Surgical site incision** – full thickness opening that closes due to primary/secondary intention or tertiary closure
- **Malignant Cutaneous Wounds (MTM)** – ulcerating skin lesions that develop when malignant cells infiltrate the epithelium
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Current wound care
- Wound cleansing
- Dressings
- Provide analgesia
- Seek consultation
- Expected outcomes – usually healing, often different outcomes for palliative patients and families

Commonly Used Products
- Hydrocolloids
- Calcium Algimates
- Foam Dressings
- Hydrogels
- Collagen dressings
- Transparent film dressings
- Wound cleansers
- Composite dressings
- Compression bandage systems

Other Products
- Honey
- Flagyl (metronidazole)
- Topical analgesics
- Hemostatic agents
Advances in practice and gaps in wound management research

Use of honey

- Historical reference of its use in medical history
- Therapeutic honeys are highly viscous & are used “raw” - do not undergo heat treatment as do culinary honeys

- Properties seen to make it useful: osmotic activity, pH, production of hydrogen peroxide, specific plant derived factors, misc. factors
- Advantage/Disadvantages
- More research needed

Advances in practice and gaps in wound management research

Wound pain management – topical and systemic


- Tran (2007) reports that evidence suggests that peripheral receptors have the ability to receive exogenous opioid agonists to produce analgesia- reducing need for increased systemic analgesia and fewer related adverse effects- used mixture of 10 mg MS injection with 8 g of a neutral water-based gel

- More research needed
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Advances in practice and gaps in wound management research

Odor management
- Alexander (2010) found odor to be the worst aspect of malignant wounds, as reported by patients/caregivers.
- Zip (2010) reports that topical metronidazole appears to be a safe and effective treatment of wound odor. 
  Although additional studies are necessary to elucidate an optimal usage pattern.
- More research is needed.

Management of bleeding
- Palm (2008) reviews a wide variety of hemostatic agents.

Benefits of palliative wound care
- Patient/family care goals – satisfactory symptom control.
- Staff satisfaction – retention, better understanding of expected outcomes.
- Quality indicators – regulations, utilization review.
- Organizational goals – cost effective.
Case Study

77 y/o female, left leg arterial bypass graft became infected, developed infection distally that ultimately required AKA. The scenario was not responding to IV antibiotics, patient was transferred to Shock Trauma for additional treatment. This was also unsuccessful, patient developing necrotizing fasciitis, decision was made to seek hospice care for goal of comfort at home.

Case Study

Patient has co-morbidities of DM, chronic kidney disease with creatinine 2.3, PVD, GERD, and h/o CVA. Wounds are purulent with exposed bone at AKA site with likely osteomyelitis. Infection spreading up leg to groin, where there is another open site. PPS on admission 20%.

Case Study

- Initial plan:
  1. **Decrease pain**
     - Dilaudid 2 MG: 2 - 4 MG PRN q2h prn Oral
     - Neurontin 300 MG: 300 MG Every Morning Oral
     - Neurontin 600 MG: 600 MG At Bedtime Oral
  2. **Manage exudate/odor**
     - Silvasorb, Dakin’s solution, ABD pads, Kling gauze
  3. **Provide emotional support**
Case Study

3 weeks later:
- Exudate decreasing
- Visit by Clinical Nurse Specialist – change to xeroform dressings for more comfortable dressing change
- PPS-40%

6 weeks post admission:
- Granulation visible, exudate significantly decreased, necrotic tissue beginning to slough
- Consult to wound clinic for possible surgical debridement

7 weeks post admission:
- Discharged from hospice for surgical debridement and closure of wound
- 3 months later:
  - Patient ultimately fitted for prosthesis, ambulatory
Organization application

What about you?

Resources

- Wound, Ostomy and Continence Nurses Association
- Calvary Hospital
- Annual Palliative Wound Care Conference
- Hope of Healing Foundation

References

References


References

- Langemo, DK. (2006). When the goal is palliative care. Advances in Skin and Wound Care.19(3) 148-54.

References

References