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# Seven strategies for optimizing end-of-life skin and wound care

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Since 1989, when Karen Lou Kennedy-Evans[1] first presented her observations on the Kennedy terminal ulcer (KTU), there has been ongoing interest in end-of-life pressure injuries (PIs) and wounds by members of the wound care community. Various descriptions, theories about etiology, and consensus documents related to practice have been proposed and published.[2,3] There are now four terms in common use to describe end-of-life wounds: KTU, skin failure, Skin Changes At Life's End (SCALE), and Trombley-Brennan terminal tissue injury.[4-7] Between 2020 and 2022, the National Pressure Injury Advisory Panel has held several conferences and webinars that have addressed end-of-life PIs and their regulatory and legal ramifications.

By whatever name you call them, end-of-life skin and wound problems are frequent, complex, and challenging. Currently, several research groups are developing end-of-life wound assessment tools. For example, Latimer et al[8] at Griffith University, Queensland, Australia, are developing a terminal ulcer assessment tool using a Delphi process, and Hill and Petersen[9] at Natchitoches Regional Medical Center in Louisiana are working on a skin failure assessment tool.

This article outlines seven strategies to help optimize the care of individuals with end-of-life skin and

## Seven strategies for end-of-life skin and wound care

| Strategy | Practice Points |
|---|---|
| 1. Develop guidelines and formularies | • Develop an end-of-life or palliative skin and wound care guideline<br>• Develop an end-of-life or palliative skin and wound care formulary<br>• Teach staff how to individualize end-of-life or palliative skin and wound care strategies |
| 2. Develop care plan templates | • Develop interprofessional skin and wound care plan templates that can be individualized for end-of-life and palliative wound care<br>• Teach staff how to individualize skin and wound care plan templates and how to document consistently |
| 3. Educate providers | • Familiarize contract service providers with the facility or practice setting's end-of-life skin care programs and guidelines<br>• Educate other facilities and services in the catchment area about the facility or practice setting's end-of-life skin care programs and guidelines<br>• Teach staff how to provide comprehensive transition-of-care orders for end-of-life and palliative wound care patients and residents |
| 4. Address process concerns | • Document skin and wound assessments on admission and regularly in the patient's or resident's healthcare record<br>• Obtain consults as necessary to help determine skin concern and wound etiology if unknown and for management recommendations as needed<br>• Provide regular staff education on wound assessment, documentation, and consultation |
| 5. Manage symptoms | • Carefully assess patients and residents with end-of-life skin and wound problems for pain, odor, and exudate<br>• Develop individualized interventions to optimize pain control, odor control, and exudate management |
| 6. Educate patients and their circles of care | • Proactively educate patients and residents, families, and caregivers about end-of-life skin and wound care<br>• Document education in the healthcare record, including content taught, the response to the education, and any evidence of learning retention or nonadherence to the plan of care |
| 7. Make a preventive legal plan | • Encourage conversations and coordination among stakeholders and safety and quality departments to develop and implement strategies for preventive legal care for end-of-life skin and wound care<br>• Provide resources that enable healthcare professionals to identify and manage end-of-life skin and wound care needs while maintaining the dignity of the patient, family, and circle of care |

wound problems (see *Seven strategies for end-of-life skin and wound care*). The goal of these strategies is to provide consistent care across the continuum including the patient's circle of care.[6] Incorporating these strategies may also help to reduce negative financial, regulatory, and legal consequences such as citations and litigation.

### Strategy 1

**Develop guidelines and formularies to support end-of-life skin and wound care, including palliative wound care, for the facility/practice setting.**

Care options are derived from care goals and may be limited by setting, cost, and personal preference. End-of-life skin and wound care is different from other skin and wound care because it is no longer focused on healing the skin condition or wound but rather on providing comfort. End-of-life skin and wound care is most often palliative in nature and aims to minimize pain and suffering and avoid complications.[10] The endpoint is not necessarily healing, although healing may occur, depending on the condition and longevity of the patient or resident. End-of-life skin and wound care is maintenance or palliative, nonhealing care.[11] If a patient at end of life experiences severe pain from being turned and repositioned every 2 hours for PI prevention, the patient's circle of care may opt for a more limited turning schedule during the day, such as every 6 hours and no turning at night, because comfort is the goal of care. The team may order a specialty support surface to reduce pressure and provide comfort. These interventions, like any deviations from the standard of care, should be documented with the rationale in the healthcare record.[12]

End-of-life skin and wound care guidelines help direct staff and should be general in nature and not too prescriptive. Many facilities use the terms "policy" or "procedures" for PI prevention; from a preventive legal care standpoint, it is better to label these "guidelines."[13] (Facilities should also have guidelines to address skin altera-

tions or wounds.) Guidelines are less rigid and allow for more individualized care, which is essential because every individual has a unique dying experience.

Once goals of care have been developed for each patient following conversations with the patient and their circle of care, the care plan and individualized interventions can be developed and documented. These conversations should include discussions about religious convictions and acceptance of comfort, palliative, and hospice care.

The products used to support end-of-life skin and wound care are often the same as those used for aggressive wound care, but the focus is different.There is more of an emphasis on products that do not cause pain on removal (silicone adhesives) or that reduce or relieve pain (topical analgesics or anesthetics), that do not have to be changed frequently (moisture-retentive or occlusive dressings), that control exudate and odor (superabsorbents, charcoal), and that keep the bioburden down to prevent infection (silver, antimicrobials, or antiseptics).[10] An end-of-life palliative skin and wound care formulary of products should supplement the guideline for end-of-life skin and wound care.

### Strategy 2

**Develop care plan templates for end-of-life skin care and wound care that can be individualized and that address appropriate end-of-life care goals.**

Plans of care for patients and residents are essential documents to guide consistent and up-to-date overall care for all patients and residents. Interprofessional skin and wound plans of care are equally essential for holistic care. Facilities often have care plan templates for PI prevention and treatment. It is just as important to develop care plan templates for end-of-life skin and wound care to facilitate the delivery and documentation of individualized care.

It is not uncommon when reviewing healthcare records to see skin and wound care plan templates that have goals such as "the skin condition will be resolved in 30 days" or "the wound will be healed in 90 days." These types of goals are usually not appropriate for end-of-life or palliative skin and wound care, where healing is not the primary goal of care. Instead, goals on skin and wound care plan templates should reflect palliative skin and wound care outcomes. For example, "Dressing change-related pain will be significantly reduced," "Wound odor will be controlled," and "Wound exudate will be managed." Educate staff about the use of end-of-life and palliative skin and wound care templates, how to individualize care, and how to document correctly and consistently.

### Strategy 3

**Educate staff and other facilities/services in the catchment area about the facility/practice setting's end-of-life skin and wound care program.**

All staff, including contract wound care providers, should be knowledgeable about the facility or practice setting's end-of-life skin and wound care programs and guidelines. This includes familiarizing others with the end-of-life wound care plans and guidelines, product formulary, the members of your wound care team, and educational materials used or referenced. There is nothing worse than inconsistent care because one physician or advanced practice clinician (APC) changes orders, such as surgical debridement, unaware that the individual's circle of care previously opted for palliative

## Strategy 3 case study

Mrs Jones, age 96 years, had a history of dementia, diabetes, and chronic kidney disease. She fell and fractured her left hip while on her way to the bathroom in the middle of the night at her assisted living facility. Mrs Jones had a "do not disturb at night" order, so it was 4 hours after her fall that she was found lying on her back on the floor.

Mrs Jones was transferred to an acute care facility and immediately following an open reduction and internal fixation experienced a stroke with right hemiparesis. On postoperative day 1, Mrs Jones developed a maroon-colored sacral deep-tissue pressure injury measuring $4 \times 3 \times 0$ cm. By day 8, the pressure injury had a dry black eschar and evolved to a full-thickness wound.

Mrs Jones' family met with her care team and after extensive discussion decided to transfer her to a skilled nursing facility on hospice. The following palliative sacral wound care orders were written on Mrs Jones' discharge from the acute care facility in her transfer orders and on her discharge instructions:

- Turn and reposition every 4 hours during the day as tolerated. No repositioning at night
- Pain medication 1 hour before turning and repositioning
- Low-air-loss mattress overlay for pain control
- Cleanse sacral eschar with wound cleanser. Pat dry. Apply silicone foam border dressing to prevent friction and shear to the wound area. Lift dressing and check daily for maintenance of dry stable eschar and document. Then reseal the dressing. Change dressing every 3 days and PRN.
- If eschar becomes moist, boggy, or unstable, contact wound care consultant services for a wound consult.

Mrs Jones died without pain at the skilled nursing facility after receiving hospice services, with her family at her bedside, 2 weeks later. Her sacral ulcer was covered by a dry stable eschar.

wound care. (Hospice care is not required for a palliative wound care pathway to be initiated.

Other facilities and services in the catchment area should also be educated about the end-of-life skin and wound care program so that care is consistent across the continuum of care. If clear direction to the accepting facility or practice setting is not provided upon transfer, the patient may be inadvertently changed to an aggressive care pathway, although it was not the pathway chosen by the circle of care. (see *Strategy 3 case study*).[11]

### Strategy 4

**Address process issues for end-of-life skin and wound care, including assessment, documentation, and consults and educate staff accordingly.**

Risk for impaired skin or tissue integrity (NANDA 2022, 00044) should be assessed on admission and regularly thereafter and documented in the healthcare record.[14] Assessment of skin conditions and wounds by a qualified healthcare professional should occur regularly and be documented.[6,12,15] If the underlying etiology of the skin condition or wound cannot be determined or if recommendations for care are needed, consults are appropriate (see *Strategy 4 case study*).[16].

### Strategy 5

**Identify methods for pain and odor control and exudate management to optimize quality of life.**

Patients with end-of-life skin and wound concerns often experience distressing symptoms, such as pain, odor, and exudate. Thoughtful attention to symptom management by healthcare staff is critical for optimizing quality of life (see *Strategy 5 case study*).[10,11,17–19]

Wound pain can be of various types, including noncyclic acute, cyclic acute, and chronic. Targeted interventions vary based on the underlying cause and the type of pain experienced. Careful assessment can lead to multiple interventions that can optimize wound pain control (see *The chronic wound pain experience model*).[10,11,17] For example, for the resident in a skilled nursing facility requiring sharp debridement of a wound, pain medication for acute noncyclic pain might include:

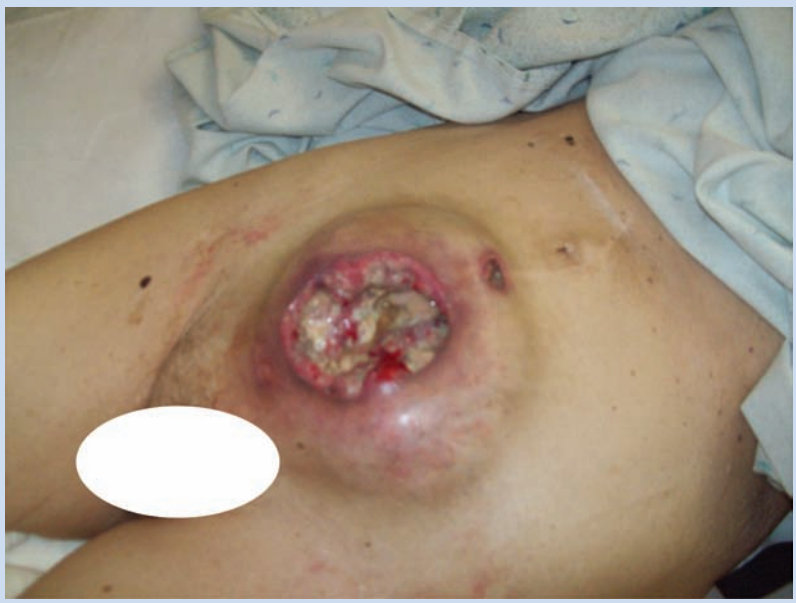
- Premedicate orally 1 hour prior to debridement
- Local anesthetic cream or gel to wound and periwound 1 hour prior to debridement
- PRN oral pain medication every 4 hours for 48 hours after debridement

## Strategy 4 case study

Mrs Smith, age 45 years, was admitted to a skilled nursing facility with hospice services for management of a fungating uterine carcinoma. Her open wound measured 15 cm in diameter. The wound was malodorous with a moderate but increasing amount of serosanguineous drainage. The periwound skin showed signs of maceration from the drainage.

Mrs Smith denied wound pain. A wound, ostomy, and continence nurse was consulted for wound management recommendations for the periwound skin breakdown and because the odor was offensive to the resident. The patient's wound dressing included abdominal pads and tape changed every 6 hours and PRN. The recommendations included:

- Cleanse wound and periwound skin gently with normal saline solution. Pat periwound skin dry.
- Apply no-sting skin barrier film to the periwound skin. Allow to dry thoroughly.
- Cut an opening in the wound pouch or drainable ostomy/urostomy pouch barrier 1/16 inch larger than the open wound diameter. Apply wound pouch or drainable ostomy/urostomy pouch.
- Empty the pouch when one-third or half full. Spray citrus room deodorizer (resident's preference) before opening the pouch to drain it.
- Change wound pouch or drainable ostomy/urostomy pouch weekly and PRN.
- Place cat litter in a plastic basin under the bed. Shake daily to optimize room odor control.



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## Strategy 5 case study

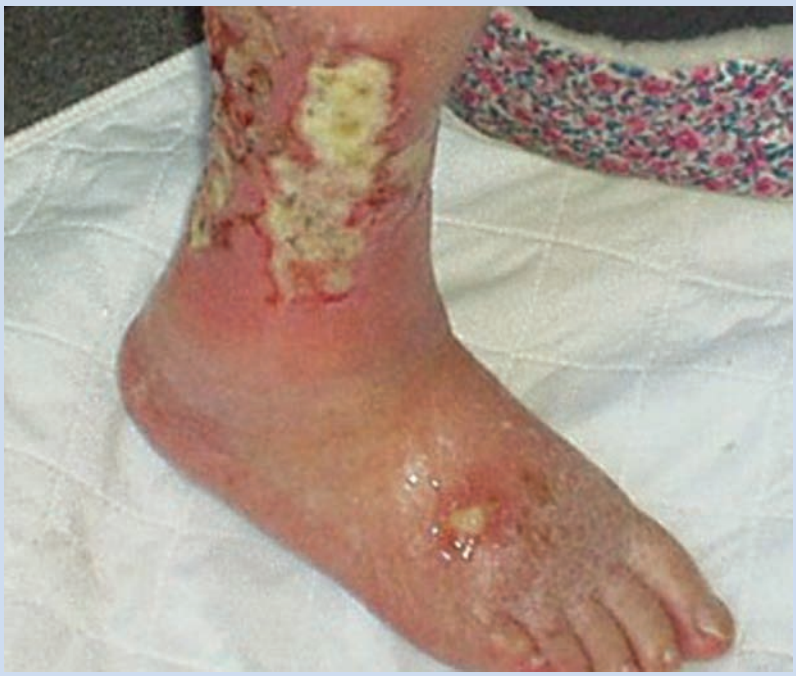
Following her acute care hospitalization for end-stage lymphoma, Mrs Long was transferred to a skilled nursing facility for wound care and pain management. A small (3 cm) but painful open wound had developed during chemotherapy on her right lower leg. Over the period of several weeks, the wound evolved into a circumferential full-thickness wound. There was significant edema of the lower leg and foot. Mrs Long refused a wound consult or an appointment at the wound clinic, so healthcare staff proceeded under a working diagnosis of "leg ulcers of undetermined etiology."

A pain assessment revealed that Mrs Long was experiencing two types of pain: procedural wound pain from wound cleansing and dressing changes and chronic wound pain of a mixed pain pattern, attributable to swelling, ischemia, and neuropathic pain.

The care team implemented the following interventions to manage her pain and exudate and optimize her quality of life:

- Premedicate 1 hour prior to dressing change.
- Cleanse wound gently with normal saline solution. Gently pat wound margins dry.
- Gently apply topical anesthetic gel with a sterile tongue blade.
- Cover wounds with foam dressings and wrap lightly with crepe wrap.
- Change dressings Mondays, Wednesdays, Fridays, and PRN.
- Elevate right lower leg as tolerated.
- In addition to PRN pain medication, use pulsed electromagnetic field therapy twice daily for pain control.

Mrs Long's pain intensity scores decreased from 12 to 6 (on a 0- to 10-point scale), and she was discharged home with home care follow-up.



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Various products (topical, systemic, environmental) can be used concurrently to address infection prevention, odor, and exudate management.[10,11,17–19]

### Strategy 6

**Educate patients/residents, families, and caregivers on end-of-life skin and wound care and document this education and the response.**

Integral to effective patient-centered care is focusing on education for patients and residents and their circles of care.[6] Proactively teaching patients and residents at end of life about their risk for skin problems and wounds can help to reduce surprise, anger, and blame. Alerting families and caregivers about end-of-life skin and wound conditions may also minimize family or caregiver burden and guilt.[6,20,21]

Written educational materials improve communication; ensure that care is transmitted accurately during transitions; and may reduce patient, family, and caregiver stress and anxiety.[22] Education should be documented in the healthcare record and describe the content taught; the response to the education; and any evidence of learning retention, such as demonstration-return demonstration or nonadherence to the plan of care.[6]

### Strategy 7

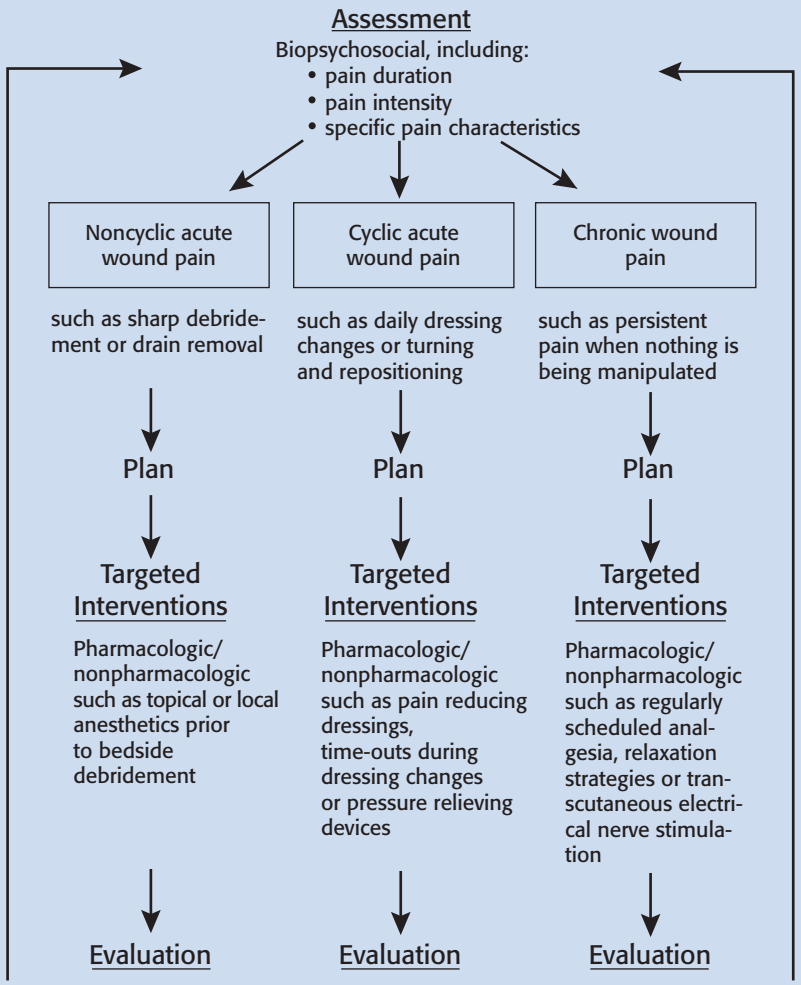
**Develop a preventive legal plan for end-of-life skin and wound care for the facility or practice setting using safety and quality resources.**

Clinicians spend so much time on PI prevention; some time needs to be spent on preventive legal care for end-of-life skin and wound care, too.[13] Physicians and APCs must facilitate communication and collaboration across care settings and disciplines; organizations must prepare staff to identify and manage SCALE.[6] Conversations and coordination between safety and quality departments in a facility or practice setting or healthcare system can result in strategies to address this issue.

## Conclusion

Incorporating these seven strategies may help your facility or practice setting optimize the care of patients and residents at the end-of-life with

## The chronic wound pain experience model






skin and wound concerns. Use these strategies to ensure the consistency of care across the continuum of care. Incorporating these strategies may also reduce negative financial, regulatory, and legal consequences, such as citations and litigation. Finally, and most importantly, these strategies can optimize quality of life and enhance dignity for patients at end of life and their circle of care. ■

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