

# Ethical Wound Management for the Palliative Patient



**A care-delivery system of intervention, education, and prevention can ease the innumerable challenges facing palliative care patients and their loved ones.**

CYNTHIA A. FLECK, RN, BSN, MBA, ET/WOCN, CWS, DAPWCA

## CASE REPORT

Ms. MZ is a 54-year-old patient with end-stage metastatic lung cancer recently admitted to hospice care. The staff members notice that despite an around-the-clock fentanyl patch and morphine as needed for pain, she cannot “get comfortable.” Her family holds a vigil around her bedside 24 hours a day, assisting with her bath, skin care, feeding, turning, and repositioning and giving her tender loving care. She finds comfort in simple things like her favorite quilt, an old photo album, a visit from her little poodle, Leo, and cheddar cheese crackers.

Upon repositioning her this morning, Ms. MZ’s husband is horrified to find a pear-shaped, yellow coccygeal ulcer that seemed to “appear overnight.” “Is the cancer coming through her skin?” he asks. He complains that his wife, “smells like death” and states, “I feel like there’s nothing I can do to help.” What is the skin and wound care treatment plan for this patient? What are the goals? How about quality of life and education for the family?

Hospice care has been front and center in the news with the Terri Shiavo case capturing the attention of Americans coast to coast. Clinicians are responsible for offering custom-tailored and effective wound and skin care in a variety of instances. End-of-life (EOL) care is no different, but it seldom makes it onto the news. Let us investigate the issues surrounding ethical skin and wound management for the palliative care patient.

### TREAT THE PATIENT FIRST

The World Health Organization (WHO) defines palliative care as “the active total care of patients whose disease is not responsive to curative treatment.”<sup>1</sup> The goal of palliative care is to therefore provide the best quality of life for the person with symptom control and a holistic approach to his or her primary concerns. The WHO further describes palliative care as treatment that affirms life and views death and dying as part of a normal process (neither speeding nor delaying death), provides relief from pain and other noxious symptoms, and offers support to patients and their significant others.

Palliative care principles address physical, psychological, social, spiritual, and practical objectives as well as individual patient needs. The primary goal of palliative management is to provide relief from suffering and improve the quality of both the living and dying processes. The point at which palliative management goals eclipse curative treatment efforts must be established with each individual patient. The rigors demanded by available treatments, the longevity of illness, and the overall health and reserves of each individual patient must be evaluated to determine what provides the highest quality of life.<sup>2</sup>

A large element of palliative care is how EOL issues and the disease process impact the patient and his or her quality of life. Since the skin is an external organ, it truly is the mirror to the soul and reflects overall health. Visible changes in the skin are usually apparent in palliative care patients, even early in their care.

In fact, hospice patients may be at greater risk of pressure ulcer development than most patients.<sup>3</sup> As exemplified in Ms. MZ’s case (see Case Report), the physical appearance of skin damage, wounds, and odor can be offensive and emotionally upsetting to the patient and his or her loved ones. These wounds can also cause pain, further compounding issues.

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Wounds, skin problems, odor, and other sequelae resulting from underlying disease can disturb body image. The psychological effect of a wound, even on an individual who is expected to make a full recovery, can include depression, anxiety, poor body image, and diminished self-esteem. It can have a profound effect on how the palliative patient relates to his or her loved ones and could disturb sleep patterns. These issues may compound the palliative patient’s experience.

The group For Recognition of the Adult Immobilized Life (FRAIL) describes a “compassionate care model” for patients with nonhealing chronic wounds.<sup>2</sup> This care model includes assessment, addressing palliative care principles, such as physical, psychological, social, spiritual, and practical objectives, as well as individual patient needs.

It further describes acceptance that complete wound closure and, in some cases, the prevention of new skin breakdown may not occur. This is a sharp contrast to our expectations, since our health system has trained us to expect disease abolition for most ailments with the ultimate goal of curing the ailment. Certainly, treatment objectives and conventional guidelines for wound care are prepared to attain the goal of complete closure.

In order to achieve the successful integration of palliative concepts into the management plan, the palliative patient and loved ones’ participation must be achieved. To facilitate that goal, education is vital. The lay public and many clinicians view the chronic nonhealing wound as totally preventable and an example of medical negligence. Therefore, a basic review of the anatomy and physiology of the skin, what to expect, and possible interventions should be discussed and agreed upon. The clinician can guide the palliative patient and family in development of achievable goals and reasonable expectations.

### CHANGES IN EXPECTATIONS AND PRIORITIES

For some chronically or terminally ill patients with longstanding or recurrent illness and/or skin ulceration, aggressive treatment may not be in their best interest. In these instances, the wishes of the patient and his or her family should be weighed carefully. Advanced directives, a living will, or a person recognized as having power of attorney should be consulted. In many instances, conservative medical care and maintaining patient comfort are the new goals, rather than the institution of major invasive procedures.

Protocols for palliative patients who have elected to pursue nonhealing objectives for their chronic wounds have stressed symptom management over wound closure. Communication is imperative at this juncture; dialogue between the staff and the patient, the staff and the patient’s significant others and family, the patient and his or her significant other, and the staff among themselves along the multidisciplinary

continuum is crucial. That is especially true when the treatment no longer involves wound closure as the primary goal and outcome. The patient's personal agenda for quality of life, comfort, dignity, informed choice, and autonomy should be your guide.

### **SKIN CARE AND MAINTENANCE OF SKIN INTEGRITY**

As the skin ages, it becomes thinner and drier and produces new cells at a slower pace.<sup>4</sup> The junction between the epidermis and dermis flattens and can become detached with subtle trauma or typical activities of daily living (ADLs).<sup>4</sup> This is a part of normal aging. Add to that issues of malnutrition, immobility, multiple comorbidities, pharmacologic intervention, incontinence, and failing health, the palliative patient has skin that is often at constant risk. Some problems encountered by the palliative patient are dry, scaly skin, itching, skin tears, and incontinence dermatitis.

The skin should be handled and treated with extreme care, as if it were a fine crystal vase or piece of heirloom china. Cleansing with a mild pH-balanced cleanser or surfactant-free lotion is best. Avoidance of soap is crucial, as it can strip the skin, drying it out and making it even more vulnerable to assault. Consider the use of some of the newer "bath in a bag" products that provide a warm comforting experience to the patient. A high-quality moisturizer should be applied head to toe after cleansing the skin. Attention should be paid to any areas of high risk, including the sacrum, the elbows, and the heels. If incontinence is an issue, a barrier containing zinc oxide, dimethicone, or 1 of the newer third-generation silicones should be applied. Petrolatum-based protectants and other primary barriers are not the best choice for palliative patients, because they need to be reapplied frequently. Instead, choose products that remain in contact with the skin despite incontinent episodes and frequent cleaning. Another key ingredient that can help soothe and comfort inflamed skin and the stinging sensation

associated with some products is methylsulfonylmethane (MSM), which not only offers antioxidant properties but can slow the conduction of pain fibers.<sup>4</sup> Another ingredient, menthol, cools and calms the skin.

Pruritus, or itching, can result from the disease process (ie, cancer) or from treatment or reactions to medications. Examples of disease states that can lead to itching include lymphomas, renal disease, leukemia, and hepatic (liver) disease. Strategies to address the discomfort of pruritus include:

- Providing an environment with a humidity above 40%
- Utilizing soap-free and surfactant-free skin cleansers
- Employing the use of high-quality moisturizers with ingredients like dimethicone
- Moisturizing the patient's skin within 5 minutes of bathing
- Applying cold compresses
- Increasing fluid intake to maintain hydration
- Avoiding alcohol and caffeine.

If the aforementioned symptom management is inadequate, consider the addition of pharmacologic agents, such as antihistamines, corticosteroids, tranquilizers, and topical therapies.

### **MOBILITY ISSUES**

Inactivity and immobility are 2 of the most challenging risk factors for skin breakdown. However, the palliative and hospice patient's activity level may mean infrequent movement and dictate little disturbance. To compound issues, the standard of turning and repositioning every 2 hours may not be recommended for palliative care, because turning and repositioning this frequently may result in unnecessary pain for the patient. It is imperative, therefore, to provide pressure redistributing support surfaces that provide comfort and take pressure off the patient's frame. Dallam et al.<sup>5</sup> found that pain was significantly lower in patients when support surfaces were used for pressure reduction. Additionally, consider a cushion for the seated palliative patient.

Support surface choice should be driven by the palliative patient's needs, with special attention paid to comfort. Surfaces that allow the patient's bony prominences to sink in, decreasing deformation of the soft tissue and allowing for optimal blood flow, are ideal. This can be accomplished by a high-quality, multidensity foam mattress replacement, a powered or nonpowered overlay, or a low-air-loss mattress replacement. The latter choice additionally helps control the microclimate of the skin, decreasing skin temperature and humidity. Time in bed often increases as a palliative patient's condition deteriorates, which occurs along with multisystem failure and growing weakness. This predisposes the patient to further risk, including decreased activity and mobility, depleted nutrition and hydration, incontinence, and changes in sensory perception and consciousness.<sup>6</sup>

Fatigue is a common symptom experienced by older adults with cancer and other incurable, progressive illnesses that negatively affect the quality of their lives.<sup>7</sup> Listen to the palliative patient when it comes to activity. Sometimes range-of-motion and conservative exercise can actually invigorate the client. The goal of managing activity and monitoring fatigue for palliative care patients is to achieve the best quality of life, given the specific circumstances that the patient faces.

### **PALLIATIVE WOUND ISSUES: MANAGING SYMPTOMS**

Pain control remains a mainstay of palliative care. Since wounds often produce pain, minimizing discomfort is paramount. Assume that every wound is painful and every patient who has a wound is in pain. Patients frequently experience pain during dressing changes (eg, from dried dressings, strong adhesives, debridement, and the pressure of exudate), around wound edges, and in infected or inflamed wounds. Wound pain can serve as an important indicator of inadequate wound management, untreated underlying cause, and/or infection. Look to dressings that can



## Revisiting Ms. MZ's case

**M**s. MZ's case is not unique. We care for palliative patients whose goals have shifted away from healing and toward improved symptom control and quality of life.

A plan of care for Ms. MZ and her family should incorporate preparing the facts, which include a complete physical assessment and history, and meeting with the patient, her husband, family, and key staff members to determine what they know and understand. After that, it is important to share information regarding the clinical condition of the patient and develop a plan of care that recognizes the condition of the whole patient and shifts treatment toward providing relief from suffering, such as wound pain, odor, frequent manipulation of the wound, and social isolation.

Specific to this patient's case would be a honing in on the involvement of the family and Ms. MZ's concerns. Mr. Z's anxiety about the cancer "coming through the skin" can be alleviated with basic education of the skin's physiology. However, since the ulcer has the appearance of an end-of-life wound or KTU, this should be explained as well. Odor and pain control can be addressed with an ionic silver dressing that can help decrease the wound's bioburden while decreasing inflammation and pain. Skin care may encompass the use of some of the newer third-generation ingredients and products like surfactant-free cleansers that do not strip the epidermis of its natural lipid protection and high-quality barriers with advanced silicones that remain in contact with the skin despite cleansing. You may want to look for products that provide 4 steps (cleansing, moisturizing, protecting, and nourishing), which decrease the stress and time of providing skin care. A pressure redistribution mattress or overlay should also be utilized to take pressure off the patient's frame and help to promote comfort and a full night sleep. Palliative care patients remain the barometer. Use your senses to assist your assessment, plan of care, intervention, and evaluation.

remain in place for longer periods of time, minimizing wound bed manipulation and decreasing the leading cause of wound pain. Moist wound healing has been demonstrated to result in faster healing, less scarring, and less pain. The pain reduction is attributed to the bathing of nerve endings in fluid, preventing dehydration of the nerve receptors.<sup>8</sup>

The following pain relief strategies are intuitive but sometimes forgotten: handle every wound gently; avoid unnecessary stimuli like drafts; protect wound edges; allow patients to change their own dressings if possible and allow them to call "time out" with a pre-arranged signal, word, or phrase; encourage

imagery and slow, rhythmic breathing; and premedicate 30–60 minutes prior to dressing change, considering the use of local anesthesia, such as EMLA<sup>®</sup> Cream (AstraZeneca Pharmaceuticals, Wayne, Pa) or Lidoderm<sup>®</sup> (Endo Pharmaceuticals, Chadds Ford, Pa).

Dressing removal is considered to be the time of most pain.<sup>9</sup> Dried dressing and adherent products are most likely to cause pain and trauma at dressing changes. Products designed to be nontraumatic should be used to prevent tissue trauma. Gauze is most likely to cause pain and should be avoided. Clinicians should avoid wet-to-dry regimens as well.

The latest products, such as hydrogels

(sheet, strands/cavity, and amorphous), hydrofibers, alginates, soft silicones, cellulose, "smart" foams—advanced foam dressings that can absorb large amounts of fluids while protecting against contaminants—and polyacrylates, are the least likely to adhere and cause pain. Be sure to select dressings with absorbency that matches exudate levels. Choose dressings that can remain in place for longer periods of time, thus minimizing the chances of wound manipulation and a harmful aggravation of the pain cycle.

Contact layers or dressings that remain in close proximity to the wound bed during dressing changes also have proven beneficial in the pain arena. Do not neglect pain management during wound cleansing, either. Appropriate noncytotoxic wound cleansers used at body temperature (~100°F) at 4–15 psi are best to keep discomfort at bay.<sup>10</sup> Avoid cytotoxic solutions, such as povidone iodine or hydrogen peroxide, when cleaning the wound.<sup>11</sup>

Simple measures like the use of skin preparations (especially the no-sting varieties) to strengthen and prepare the skin for adhesive application provide less trauma to tender periwound skin. Use them whenever you dress a wound. Consider tape alternatives, such as netting, tubular dressings, Velcro wraps, and Montgomery straps, to attach dressings. If the dressing gets dry, moisten it with wound cleanser or normal saline to soak it prior to removal.

Silver dressings, especially ionic silver hydrogels, can be ideal pain-free dressings. These dressings provide a broad-spectrum antimicrobial action with no known resistance and maintain moisture balance with pain-free application and removal. They also provide for autolytic (eg, pain-free) debridement and display anti-inflammatory actions while eliminating any offensive odors.<sup>12</sup>

Prevention and treatment of infection in the palliative patient is not necessarily to facilitate wound healing, but appropriate care must be supplied to prevent further decline of the patient's general status while relieving concurrent pain or discomfort. In lieu of qualitative



or quantitative biopsies or swab cultures, consider treating empirically with a broad-spectrum topical antimicrobial like polyhexamethylene biguanide (PHMB) or ionic silver. Clinical signs and symptoms to watch for include pus, warmth, pain, erythema, induration, discoloration, friable granulation tissue, and pocketing of the wound base.<sup>13</sup>

Control of wound odor is imperative for palliative clients. Similar to control of incontinence, control of wound odor can significantly improve the quality of life for palliative patients with nonhealing wounds. Strategies include identifying the cause of the odor and working to eliminate it. Cleansing these wounds with antimicrobial wound cleansers containing safe ingredients like benzylkonium chloride (BZK) and identifying wounds with high bioburden and treating them with a safe, pain-free

antimicrobial are good first steps. Treating the cause is more effective than simply spraying an odor eliminator.

Many chronic wounds, especially critically colonized and infected wounds, produce large amounts of exudate. Wound exudate can be caustic and therefore painful to the periwound tissue. The dressing regimen should be chosen based on the wound's exudate level. Dressings developed to handle moderate to large amounts of exudate include some hydrocolloids, glycerin-based hydrogel sheets, alginates, alginates and carboxymethylcellulose (CMC) combinations, foams, polyacrylates, and cellulose. The goal should be to minimize dressing changes while providing for adequate drainage absorption. This will help optimize the patient's social interaction and activity level and is an important objective for palliative non-

healing wounds.

Skin tears are traumatic acute wounds that happen when the epidermis and dermis separate at the junction of the rete ridges. As the skin ages, the incidence of skin tears increases due to the thinning of the epidermis and dermis and the flattening of the rete pegs. Thomas et al.<sup>14</sup> estimated that 1.5 million skin tears occur every year in institutionalized adult patients. Most skin tears happen on the extremities, especially the arms and hands. They often occur during normal ADLs.

Basic strategies to prevent skin tears can be employed, such as clothing patients in long sleeves, using gentle adhesives and paper tape, judiciously using pillows and blankets in the recumbent environment, using tubular stretch dressings that protect the periphery, and educating staff on using a gentle hand.

# The Buck Stops Here

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Skin tears can more effectively be prevented by providing gentle skin care with pH-balanced soap and surfactant-free cleansers, moisturizers containing amino acids and free-radical scavengers like grape seed extract, vitamin C (ascorbic acid), or hydroxytyrosol (from olives), and essential fatty acids like Omega 3, 6, and 9.<sup>4</sup>

Additionally, barriers containing silicones and dimethicone can provide an extra invisible layer of protection from skin tears. In a study of 100 residents, a long-term care facility that provided a traditional skin care regimen of cleaning, moisturizing, and protecting the patient's skin with a well-known pH-balanced skin care line had a nosocomial incidence of 1 or more skin tears per day. After incorporating a new advanced skin care line containing Olivamine (specially treated amino acids and hydroxytyrosol), the facility dropped its nosocomial incidence rate to only 2 skin tears in a 6-month period (both of these skin tears were traumatic enough to cause a skin tear in a young healthy individual).<sup>15</sup>

Consider looking beyond the obvious closure strips and transparent dressings for treatment of skin tears. Check out some of the gentle foams, cellulose, and soft and flexible hydrogel sheets that can provide a gentle, cushioning, flexible, nonadherent, and semi-occlusive, soothing environment for pain relief and healing. These dressings also allow visualization without disturbing the wound bed.

Pressure ulcers are a common occurrence during the dying process. Kennedy reported that 56% of patients who died in an intermediate care setting developed pressure ulcers within the 6 weeks prior to their deaths.<sup>16</sup> She also described a "terminal ulcer" having the following characteristics: appears suddenly when death is imminent (within 14–21 days), is located on the coccyx and/or sacrum; and is yellow, red, or black in color. She named it the Kennedy Terminal Ulcer (KTU).<sup>16</sup>

### PREVALENCE AND INCIDENCE

The National Pressure Ulcer Advisory Panel (NPUAP) reviewed the literature

over a 10-year period to determine prevalence and incidence of pressure ulcers in palliative care and hospice patients. Incidence rates ranged from 8%–85%, with the majority of the patients having cancer. Locations for these ulcers were the sacrum (38.4%), the heels (15.4%), and the elbows (30.7%). This literature review further showed that pressure ulcers occurred within 2–3 weeks of death and had a higher incidence rate in elder patients with cancer compared to a matched group without cancer.<sup>6</sup>

Care of percutaneous tubes, drains, and fistulae should be addressed with the same "pain-free" mantra. Consider novel dressings that offer exudate control, do not adhere to the site, and can remain in place for longer periods of time to reduce manipulation and also dressings with impregnated antimicrobials to reduce bioburden and possible odor.

### CLOSING THE GAP

An individual at the end of life is prone to a multitude of challenges, among them skin changes and wounds. Early intervention, education, and prevention can offer comfort and relief to the patient and family as well as the clinical team. Discuss options with your staff involving social service, chaplain care, wound management experts like wound, ostomy, and continence nurses (WOCN) and certified wound specialists (CWS), the medical director, nursing leadership, and administration. Providing a peaceful skin and wound care experience with the patient's comfort and choice reigning high offers empowerment and gives the palliative patient control in hopes of increasing quality of life. ■



*Cynthia A. Fleck, RN, BSN, MBA, ET/WOCN, CWS, DAPWCA, is a board-certified wound specialist, writer, and speaker and the Vice President of Clinical Marketing for Medline Industries Advanced Wound and Skin Care Division. She presents seminars and educates clinicians on skin and wound management and has been an invited*

*speaker and lecturer at university, national, and international symposia. Cynthia is also a member of ECPN's Editorial Advisory Board. She can be reached at [cfleck@medline.com](mailto:cfleck@medline.com) or by telephone at 800-965-2167, extension 7956.*

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