PALLIATIVE WOUND CARE: HOW THEORY MEETS BEDSIDE.

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OBJECTIVES

1. Describe the difference in hospice and palliative care.
2. Discuss symptom management in palliative care.
3. Identify practical approaches that integrate basic wound care principles into palliative care.
“We live in a very particular death-denying society. We isolate both the dying and the old, and it serves a purpose. They are reminders of our own mortality. We should not institutionalize people. We can give families more help with home care and visiting nurses, giving the families and the patients the spiritual, emotional, and financial help in order to facilitate the final care at home” 1972, Dr Elisabeth Kubler-Ross at a U. S. Senate special committee on aging hearing (National Hospice & Palliative Care Organization[NHPCO], n.d., p.1).
The History of Palliative Care

- Started as a hospice movement in the 19th century, religious orders created hospices that provided care for the sick and dying in London and Ireland.

- In recent years, Palliative care has become a large movement, affecting much of the population.

- Began as a volunteer-led movement in the United States and has developed into a vital part of the health care system.
The goal is to improve the quality of life for individuals who are suffering from severe diseases.

Palliative care offers a diverse array of assistance and care to the patient.
Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patient actively as possible until death;
offers a support system to help the family cope during the patient's illness and in their own bereavement;

uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;

will enhance quality of life, and may also positively influence the course of illness;

is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.
Palliative care can be provided from the time of diagnosis.
Palliative care can be given simultaneously with curative treatment.
Both services have foundations in the same philosophy of reducing the severity of the symptoms of a sickness or old age.
HOSPICE: The patient has *both*
• a limited life expectancy (specifically six months or less);
• *and the goals for care are exclusively to achieve and maintain comfort, regardless of the symptom burden.*

PALLIATIVE CARE: The patient has *either*
• a limited life expectancy (regardless of symptom burden or goals for care),
• *or a significant symptom burden (regardless of prognosis or goals for care) or goals for care exclusively to achieve and maintain comfort (regardless of prognosis or symptom burden).*
Division made between these two terms in the United States

Hospice is a “type” of palliative care for those who are at the end of their lives.

Image courtesy of http://www.ersj.org.uk/content/32/3/796.full
Palliative Care

Graphic by Anne Kinderman, MD; used with permission.
SYMPTOM MANAGEMENT AND PALLIATIVE CARE

the goals of healthcare are "to cure sometimes, relieve often, and comfort always." Hemani, 2008.

1. Symptom management
2. Patient/family goals
SYMPTOM MANAGEMENT IN PALLIATIVE WOUND CARE

- pain from the wound
- odor/smell
- amount of drainage
- pain from dressing changes
- bleeding
- appearance of the wound
- Itching

Usually listed as last goals as they may be the most difficult to modify

- decreasing wound size
- complete healing of the wound

Emmons, 2014
Symptom Management in Palliative Wound Care

- Prevention of deterioration and stabilization of the wound
- Promotion of a clinically clean and protected wound environment
- Minimization of infection and sepsis
- Control of pain, odor and excessive exudate
- Reduction in the frequency of dressing changes
- Minimization of bleeding
- Prevention of trauma
- Management of maceration
- Elimination of pruritis

Emmons, 2014
Explain and document that complete wound healing may not be a primary outcome 2/2 (list conditions, end stage..., arterial disease, Ca, etc). The plan of care will focus on meeting the needs of the patient/family. By providing excellent care, if physiologically possible, wound healing may occur.

Ask the patient and family, what is most bothersome about the wound.

List out of the problems and develop a plan for each issue.

Prioritize each issue based on what is the worst and what can be achieved.

Set realistic goals

Emmons, 2014
ETHICAL CONSIDERATIONS

- Beneficence: do good
- Non-maleficence- do no harm
- Autonomy-patient’s right to decide
- Justice-fairness
Pressure ulcers,
Skin tears,
Venous and/or arterial leg ulcers,
Diabetic ulcers,
Fungating/malignant wounds.
Happy wounds are healing wounds
WOUND MANAGEMENT

3 requirements for wound healing

- Etiology- what “caused” the wound. Try to correct or manage the cause.
- Systemic- is the pt ‘able” to heal? Education to pt to improve healing ability.
- Topical- what is done to the wound to make the wound happy. Happy wounds are healing wounds. Based on DIPAMOPI.
Determine the cause

Correct or manage the cause
- Pressure-support surfaces, turning, etc
- Venous stasis-compression
- Arterial-vascular consult
- Surgical-NA
- Diabetic-glucose control, offloading
- Atypical-varies, referral to dermatology (?)
- Skin tears-improve skin integrity, pad items
**Systemic Support**

- Nutrition-protein 1.2-1.5g/kg/d & calories 30cc/kg/d
- Perfusion-decrease reducible factors
- BMI-appropriate wt/ht
- Activity-
  - Glucose management
  - Hydration-30cc/kg/d typical
- Immune system
- Manage co-morbidities
TOPICAL THERAPY

- D  Debride any non viable tissue
- I  Infection
- P  Pack dead space
- A  Absorb exudate
- M  Maintain moist environment
- O  Open closed wound edges
- P  Protect from trauma
- I  Insulate

Addressing ALL of these components make for a happy wound.
**WOUNDS: HAPPY VS. SAD**

- Moist
- Warm
- Protected from trauma
- Controlled bacteria (bioburden)

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- Soupy wet or dried out.
- Cold (frequent changes)
  - Lots of necrotic tissue
  - Infection
  - Pressure
Statement 9: The probable skin change etiology and goals of care should be determined. Consider the 5 Ps for determining appropriate intervention strategies:

- Prevention
- Prescription (may heal with appropriate treatment)
- Preservation (maintenance without deterioration)
- Palliation (provide comfort and care)
- Preference (patient desires)
RISK ASSESSMENT TOOLS

- Braden
- Norton
- Hunters Hill (specifically for Palliative Care)
UNSTAGEABLE
PAIN IS MOST BOTHERSOME
Pressure Ulcers

Although risk can be assessed to develop individual care plans, all palliative patients are high risk and should be treated the same. The three ingredients of a successful prevention program include 1) pressure relief/redistribution for bed and chair, 2) pressure relief/redistribution for heels, and 3) lubricating the skin with aggressive emollient therapy. (Tippett 2012)
STAGE 4 NECROTIC TISSUE
LEG ULCERS

- Most bothersome symptoms: Drainage and itching
- Itching---lanolin and topical abx can exacerbate eczema and actually cause itching
- Venous Hypertension: Back pressure on the venous system exerted either from central or pulmonary sources, or from extrinsic compression syndrome. Example, a mass, tumor or tight girdle.
- Venous Insufficiency: An obstruction which blocks outflow, valvular incompetence, which permits retrograde flow, or muscle pump failure, resulting in incomplete emptying of the venous system in the lower leg.
- Venous Leg Ulcers: Wounds that usually occur on the lower leg in people with venous insufficiency disease. Venous Leg Ulcers are also known by such terms as venous stasis ulcer and venous insufficiency. Ulcers result from chronic venous hypertension caused by the failure of the calf muscle pump.
VENOUS LEG ULCER
LEG ULCERS WITH CHF

- CHF - dyspnea
LEG ULCERS

- Venous stasis ulcers
- Other:
  - Rheumatoid arthritis
  - PVD/Arterial wounds/gangrene
DIABETIC ULCERS
ARTERIAL OR VENOUS?
WHAT DO YOU DO?
MALIGNANT FUNGATING WOUNDS
HOW FAST CAN IT HAPPEN
ENTEROCUTANEOUS FISTULA
Clean - Free of bacterial proliferation eliciting no response from the host.

Contamination - The presence of bacteria on the wound surface without proliferation.

Colonization - Presence and proliferation of bacteria eliciting no response from the host.

Infection - Invasion of bacteria which proliferates and elicits a response from the host e.g., erythema, pain, warmth, edema, exudates

Bacterial balance describes the bacterial level present in a wound and their ability to cause damage or infection. All chronic wounds contain bacteria. However, the impact of these bacteria on healing is dependent on several factors, including the number of organisms, the virulence of these organisms and host resistance (Sibbald, Woo, & Ayello, 2006).
QUESTIONS??

- Bdale@qualityhomehealth.com
- Woundostomycontinence.com
- WOCN.org
Special shout out to Dr Emmons for sharing your wisdom and resources!

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REFERENCES


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