INTRODUCTION

by Aletha Tippett, MD

Palliative wound care is a relatively new field that focuses on the wound treatment of individuals at the end of life, those with terminal disease or those unable to tolerate standard care. Rather than embracing a strategy to “heal” a wound or prepare it for surgical closure, which may involve procedures that increase discomfort and care costs, the treatment goals for an individual qualifying for palliative wound care are to provide comfort measures and manage the symptoms associated with the person’s condition. Palliative care affirms life by supporting individuals and their family’s goals to ensure the best quality of life regardless of the person’s stage of illness.

Even with limitations on wound healing, it is inappropriate to ignore wounds or declare them untreatable or unpreventable in individuals at the end of life. An effective palliative wound program has many benefits, including improved quality of life and achievement of the goal of healing the whole person. Palliative care goals work in tandem with those aimed at complete wound closure, addressing objectives focused on quality-of-life issues for both the individual and his or her family. Palliative wound care is ideal for those wounds in which the underlying etiology does not respond to treatment or the demands of treatment are beyond the person’s tolerance or stamina. Surprisingly, good palliative care can result in wound healing in nearly half of individuals receiving treatment.

An all-embracing approach to palliation in wound care involves:

- Assessing the individual and his or her wound(s) to determine whether palliation is appropriate (page 4)
- Developing a comprehensive strategy for palliation of various types of wounds: pressure, arterial, malignant, neuropathic and stasis (page 5)
- Managing symptoms of chronic wounds, especially pain and odor (page 7)
- Considering alternative treatment modalities, including biotherapy (page 8)
- Choosing proper support surfaces to enhance care of the person and their wound(s) (page 9)
- Considering an interdisciplinary approach with nutritional support and surgery as indicated (page 13)
This paper will explore palliative wound care through the perspective of an interprofessional team of wound care providers, creating a framework for an effective palliative wound care program. Clinical guidelines combined with viewpoints and anecdotes will offer a holistic approach to the assessment, strategies and practical management of the palliative individual.

Assessment for Palliative Wound Care

**ASSESS THE INDIVIDUAL:**
Assessment of the individual for palliative wound care is not much different from the assessment for any other wound patient. Initial questions that should be asked in your assessment include:

- How old is the individual?
- What is his or her primary diagnosis and how does it relate to the wound(s)?
- Does the individual have a strong support system of family and caregivers?
- What would the individual and his or her family like to have happen in regard to care?
- Is the person in hospice?

These questions need to be answered to guide you in taking any further action in the person’s care. First and foremost, the goal is to take care of the individual in a way that he or she will allow. Maybe you have been called to see an individual with a wound, but pain is the main problem, and the person longs to be out of pain. The objective should be to address the individual’s pain first, and then approach the treatment of the wound once the pain has been managed. Or perhaps the individual has a wound, but the main concern is with its odor. The person’s request may be to just control the odor so he or she can be with family members.

**ASSESS THE WOUND:**
If, in your preliminary assessment, you see that the wound is something that needs to be addressed, determine what kind of wound it is and how it developed:

- What is the wound type?
- What is the location of the wound?
- Have the etiology and related risk factors of the wound been determined and addressed?
- How long has the wound been present?
- Is the wound painful?

These are just a few of the questions that will require investigation in order to help you determine what strategies you could use in approaching the management of the wound. (*Refer to page 5, Palliative Wound Care Strategies.*)

**DEFINE OBJECTIVES:**
Once you know what type of wound you are working with, go back to the individual and ask the following questions to define the scope of care you are to provide:

- What are the goals of the individual?
- How long does the person have to live?
- What interventions will the person allow?
- Are the goals of the individual supported by family members and caregivers?
If the individual is near the end of life and/or has terminal illness, or is tired and doesn’t want further curative efforts, then he or she qualifies for palliative treatment. Remember: the goals in palliative wound care are to reduce pain, prevent infection, control odor and improve quality of life for the individual. Any treatment program must be consistent with these goals. Answering these questions, discussing goals with the individual and his or her family, and approaching his or her care with these responses in mind will help you determine the best approach in managing the wound condition.

**Palliative Wound Care Strategies by Wound Type**

Once the individual has been thoroughly assessed for palliative care and his or her objectives and needs have been discussed, the wound care provider must determine the wound management strategy to follow. This strategy will depend upon the type of wound being treated for palliation. A summary of each type of wound and an appropriate palliative strategy are listed below, including factors such as removal of the wound cause, pain and drainage management, and odor control:

<table>
<thead>
<tr>
<th>TYPE</th>
<th>STRATEGY</th>
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<tbody>
<tr>
<td>Pressure ulcer</td>
<td>Remove source of pressure. Use appropriate pressure support surface on bed, chair and heels (static air preferred). Dress wound with moist wound dressing.</td>
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<tr>
<td>Shear</td>
<td>Remove cause of shear. Arrange care such that shear does not recur or is minimized.</td>
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<tr>
<td>Arterial/Ischemic</td>
<td>Use betadine (povidone iodine) to keep wound dry, clean and disinfected. Control pain. If individual is ambulatory, consider vascular consult for endovascular therapy. Manage odor from ischemic tissue.</td>
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<tr>
<td>Venous stasis</td>
<td>If individual will allow, elevate legs and use compression wraps (if ABI &gt;0.7). If individual will not allow, then just keep absorbent pads under feet to collect drainage.</td>
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<tr>
<td>Tumor</td>
<td>Can use infant diapers or other incontinent containment products for drainage, especially helpful for breast tumors. A spray of viscous lidocaine/normal saline with several drops of oil of wintergreen makes a soothing aid for odor—spray on as needed. Can use alum to staunch bleeding. Use dark towels in case of bleeding. Maggot therapy may be helpful in reducing odor and necrotic tissue.</td>
</tr>
<tr>
<td>Fistula</td>
<td>If unable to use usual drain techniques, apply thick layer of zinc oxide around fistula opening and place plastic bag over it, pressed into the ointment, to collect drainage. Commercial pouches (ostomy or fistula) are available that may also be used to collect drainage.</td>
</tr>
<tr>
<td>Gangrene</td>
<td>If dry, paint with betadine and do not disturb. It will autolytically debride. If it is wet, maggots are the first choice to debride and eliminate infection. Conservative debridement may also be a consideration.</td>
</tr>
<tr>
<td>Intertriginous rash</td>
<td>Keep skin folds clean and dry, put cloth in folds. Antiperspirant is sometimes helpful.</td>
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<tr>
<td>Incontinence dermatitis</td>
<td>Treat incontinence if possible (foley catheterization, toileting); use zinc oxide ointment, open diaper or incontinence product under individual when in bed. Can add open infant diaper to increase absorbency.</td>
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</table>
As shown in the above strategies, knowing what type of wound you are managing is the key to choosing the correct strategy. Also, bear in mind that how a wound is dressed is not nearly as important as removing the cause of the wound, if possible.

Alternative therapies, if appropriate, may be sought to help meet the objectives of the individual and wound care provider. In implementing a wound care strategy, discuss the treatment program with the individual and his or her family and educate them about the options.

VIEWPOINT ON SYMPTOMS MANAGEMENT: IMPROVING COMFORT AND DIGNITY

by Aletha Tippett, MD

What is palliative care relative to wound treatment? In brief, it involves humanity, caring and compassion. I once saw a 90-year-old woman in a nursing home. She had hip and ankle fractures, and developed a sacral ulcer in the hospital. She was in excruciating pain, screaming at every touch. To correct her turned-in hips, she was trussed up in a hip abductor device—she called this “the dragon”—that was highly uncomfortable for her.

On top of all this, the devices were creating wounds on her feet and ankles. She had stage IV coccyx wounds and an overabundance of tape holding the dressings. The screaming when these were removed was tremendous. The individual had on a diaper and sweatpants. To remove these caused more screaming from the discomfort. Her son had recently insisted that her pain medication be changed from Oxycontin to Vicodin because the former made her too sleepy. The individual was not eating well because of her severe pain and side effects of the medication.

What is the palliative thing to do in this situation? This 90-year-old woman needs (and deserves) comfort and dignity.

• First, no diaper or pants. Just put the diaper flattened out beneath her and cover her with a sheet and blanket or a gown.
• Second, no tape for the dressings. Instead, use medicated hydrogel with lidocaine, put zinc oxide around the wound, and top the wounds with plastic wrap.
• Third, eliminate all orthopedic devices. She will be more comfortable and be able to move more without them.
• Fourth, provide static air overlay for flotation and easier positioning and transfer. Her low air loss bed can be replaced with a regular foam mattress.
• Fifth, provide air boots for heels that are lightweight and washable.
• Sixth, provide adequate pain relief, starting with Os-Cal with Vitamin D for bone health, methadone 2.5mg every night for touch-me-not pain, and Oxycodone 30 minutes before dressing changes.

When we were done instituting these changes, the individual was resting comfortably. She was smiling and talking. Her son and primary care physician were included in the care plan and were in agreement,
which pleased her. The individual was seen two weeks later in follow-up and her sacral wounds were healing well. The foot and leg wounds were almost gone, her pain was well controlled, and she was smiling. The changes allowed her to be more comfortable, to move better, and to eat better. Beyond helping the person, this new system of care was easier for her caregivers to provide.

Will her wounds heal? If she lives long enough, yes. Her wounds may heal. Will she be comfortable? Yes. Is her dignity honored? Yes.

This is compassionate, humanitarian care.

**SYMPTOMS MANAGEMENT**

*by Kestrel Editors*

A key treatment objective in palliative wound care is managing the symptoms of the wound. As discussed above, depending on the wound and the goals of the individual, treatment and management strategies can take on a variety of forms.

**INFECTION:** Infection of a chronic palliative wound produces an enhanced and prolonged inflammatory response, which in turn causes more damage to the wound. Consequently, symptoms that would normally indicate the presence of an infection would be masked, because the prolonged inflammatory response also reduces the individual’s immune response.

Depending on the nature of the infection, either systemic or local antibiotics may be used to combat the infection. Drainage or debridement may be necessary to remove slough and devitalized tissue, because these slow wound healing and can affect the efficiency of topical antibiotics. Antimicrobial dressings, including those that use silver technology, may be used to help reduce bioburden. Antibiotics, whether topical or systemic, should be used only under the explicit direction of a physician.

In addition to removing a barrier to wound healing, treating the source of infection in palliative wounds can mitigate other symptoms, such as wound odor, exudate and pain.

**PAIN:** Dressing removal is often the most painful part of the wound management regime. Analgesia should be given systemically or topically before the dressing change procedure begins, with enough time allowed for the analgesic to have the desired effect. Pain can be limited with the use of dressings that are minimally traumatic upon removal and by gentle irrigation of the wound area with warmed normal saline prior to removal of the dressings.

**WOUND ODOR:** Wound odor, although not technically a barrier to healing and wound health, needs to be taken into account because of its psychological effects on the individual. Malodorous wounds can negatively impact the individual’s relationship with family and friends, contributing to social isolation. Bacteria present in the wound create wound odor. Limiting the bacterial burden on the wound, managing
Exudate and applying odor-controlling dressings such as those containing charcoal or carbon can all help to reduce wound odor.\

**EXUDATE:** Although moist wound healing has been well received in recent years as an effective method of wound management for certain types of wounds, chronic palliative wounds present a particular challenge. Proteinases (tissue-destroying enzymes) present in wound exudate damage periwound skin and can enlarge the wound. Absorbent dressings should be used to manage heavy levels of exudate, and can be used in conjunction with a non-adherent contact layer to minimize dressing change trauma. However, in cases where the wound bed can be allowed to dry out and the amount of exudate reduced, this approach may be preferred to moist wound healing. Because the priority is reduced discomfort for the individual receiving care, not faster wound healing, dry wound healing may be a viable approach with minimal negative impact on the individual.

**NUTRITIONAL SUPPORT:** As an individual becomes weaker and less alert, he or she is often unable to maintain oral intake of nutrition. Additionally, certain medications or symptoms of chronic conditions can affect the absorption of nutrients. Without proper nutritional support, the risk of skin damage and delayed healing increases significantly. As a result, the need to encourage the individual to eat and drink frequently can outweigh other dietary restrictions. One approach to increasing nutritional intake is to offer the individual his or her favorite food or beverage. (Refer to page 13, Offering Supportive Nutritional Care at End of Life.)

**SELF-CONFIDENCE AND INDEPENDENCE:** As an individual’s condition worsens, the psychological implications of reduced independence can be devastating. When possible, promoting self-care and the continued performance of certain everyday activities can help to improve patient individual, outlook and quality of life.

**VIEWPOINT ON ALTERNATIVE TREATMENTS: MAGGOT DEBRIDEMENT THERAPY IN NECROTIC TUMORS**

*by Ronald Sherman, MD, MSC, DTM&H*

In approaching the management of an individual qualifying for palliative care, alternative treatments such as biotherapy may be considered.

I was recently asked about using maggot therapy for treating a cancerous tumor that eroded through the skin, causing a foul-smelling, necrotic draining wound. This is not an uncommon question, and it touches upon several important elements of biotherapy, as well as palliative wound care in general. Let’s first explore the approach to this clinical situation. Then we will look at the data concerning maggot therapy for necrotic tumors.

Good palliative wound care—like good health care in general—begins with addressing the individual’s needs and desires (acknowledging, however, that their needs do not necessarily match their desires). Next, we should put our own goals for the individual into perspective. Finally, we must integrate the two sets of objectives and prioritize them.
For palliative wound care, the priorities are typically debridement, pain control, drainage control, odor control, infection control and anxiety control. Safety, simplicity and cost containment are often additional considerations. Complete wound healing may be desirable, but is nevertheless designated as “low priority” if unlikely to be achieved. Still, wound healing does not have to be left off the palliative wound care list of objectives. Indeed, good wound care—including debridement, control of drainage and infection, and pressure relief—often leads to improved healing, especially when co-factors such as nutrition and anemia are also optimized.

So what were appropriate goals for the person referred to me, and how did maggot therapy fit into the picture? The objectives for this individual were control of pain, odor and drainage, through debridement of the necrotic tissue. Tumors themselves are living, but when they outgrow the local blood supply, they may become ischemic and die. Additionally, as they grow they may erode into the skin or subcutaneous tissue, causing necrosis of the normal soft tissue, as in this case. Maggot debridement dissolves and debrides only the necrotic tissue, not the healthy skin or the viable cells in the tumor. In other words, maggot debridement therapy (MDT) is not a cancer cure; it is only for management of necrotic tumors and wounds.6

There are no published controlled clinical trials of maggot therapy for necrotic tumor or palliative wound care; however, several insightful case reports and case series do specifically address this topic;7,8,9,10,11 Additionally, many published studies outside the strict definition of palliative wound care also describe the efficacy of maggot therapy for attaining the same goals that we have with individuals receiving palliative wound care: debridement, infection control, pain, odor and drainage control, etc. They are too numerous to discuss here—they could take up a full-length review. Let it suffice to say that MDT should definitely be a consideration not only for limb salvage and debridement of problematic wounds, but also for the symptomatic relief of painful, draining, foul-smelling wounds, whether or not the individual is in hospice. MDT is simple, inexpensive and safe enough that it should not be withheld for any reason unless more effective alternatives are available, contraindications are present or the individual declines therapy.

EFFECTIVE SUPPORT SURFACE SELECTION IN PREVENTING AND TREATING PRESSURE ULCERS

by Kevin Y. Woo, BSc, MSc, PhD, RN, GNC(C), ACNP, FAPWCA

Pressure ulcers are a significant problem across the continuum of health care settings, especially in vulnerable populations such as individuals at the end of life. In 2009, the overall prevalence was 12.3% (N=92,408) in the United States, according to a national survey.12 The burden of pressure ulcers is significant; the average cost associated with the treatment of deep pressure ulcers and related complications is US $129,248 in acute care. People with pressure ulcers are beset by limited mobility, social isolation, depression, and persistent pain. In reviews of 53 studies, support surfaces (e.g., medical-grade sheepskin, high-specification foam mattresses) have been recognized as reducing the incidence of pressure ulcers. Appropriate surfaces or mattresses facilitate pressure redistribution, remove pressure to injury-prone areas (especially bony prominences) and spread weight evenly to avoid pressure buildup. Foam, gel-filled, water-filled and low air loss mattresses are commonly used. They are considered “reactive” because the effect of pressure redistribution is determined by the surface area of the body in
contact with the mattress; the larger the area of the body that is supported by the mattress, the lower the pressure at any given point of contact.

The majority of specialty surfaces are expensive, but taking into account the number of ulcers that can be prevented, the calculated cost of using therapeutic surfaces and other preventive measures is approximately 1/40th that of the standard care approach. Amid the wide variety of options, clinicians should understand how to make the selection of the right mattress/surface for the individual (which?), the right clinical indication/circumstances (when?) and the right length of time (how long?) to get the right health outcomes (what to expect?). The mnemonic MATTRESSES highlights 10 key factors that should be considered prior to using a support surface to ensure the cost-effective use of resources to prevent pressure ulcers. The comfort and management of wound symptoms of individuals receiving palliative care should weigh heavily in the selection of support surfaces for these people.

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>RATIONALE</th>
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<tr>
<td>M</td>
<td>Microclimate and moisture:      Low air loss for moisture problems (e.g., sweating) and heat accumulation</td>
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<tr>
<td>A</td>
<td>Activity levels:               Certain surfaces may hinder mobility in bed and individual’s ability to get out of bed</td>
</tr>
<tr>
<td>T</td>
<td>Tissue tolerance:              Tolerance to pressure and other mechanical forces is determined by local perfusion and oxygen delivery</td>
</tr>
<tr>
<td>T</td>
<td>Total body weight:             Individuals with extreme BMIs (high or low) are more susceptible to pressure damage</td>
</tr>
<tr>
<td>R</td>
<td>Repositioning needs:           Repositioning surface is lacking or individual presents with condition(s) that create repositioning challenges</td>
</tr>
<tr>
<td>E</td>
<td>Edema:                        Dynamic pressure may aid edema management by promoting lymph flow and air circulation for weeping edema</td>
</tr>
<tr>
<td>S</td>
<td>Shear and friction:            Surfaces that conform to the body may prevent sliding and associated shear damage to the tissue</td>
</tr>
<tr>
<td>S</td>
<td>Symptom management:            Pain, shortness of breath, fatigue, and other associated symptoms</td>
</tr>
<tr>
<td>E</td>
<td>Existing pressure ulcer(s):    Existing pressure ulcer(s) indicates that the person is at risk for further skin breakdown</td>
</tr>
<tr>
<td>S</td>
<td>Sites:                        Heels are more prone to pressure ulcers; heels should be managed independently of the support surface</td>
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**How to Select a Surface: Think MATTRESSES**

**M—MICROCLIMATE AND MOISTURE:** Increasing attention has been drawn to the role of “microclimate” in pressure ulcer care. Microclimate refers to the environment at or near the skin surface that is influenced by the combined effect of skin temperature, humidity/moisture and air movement. An increase of 1°C in skin temperature results in an increase of approximately 13% in tissue oxygen demand, making the skin more vulnerable to mechanical damage. Excess moisture from incontinence, sweating and wound exudation can cause skin maceration, weakening the connections between epidermal cells and collagen fibers. The interruption of normal barrier function increases skin permeability to irritants and pressure damages.
Certainly, heat and moisture accumulation are directly related to air movement at the interface between the skin and the support surface. Some foam mattresses have poor heat properties and tend to “hug” the body, limiting airflow. In contrast, low air loss or air-fluidized beds (with vapor-permeable covers) promote air circulation that cools the skin through convection and evaporation of moisture from the skin. This type of mattress may be beneficial for individuals with severe burns. Other simple measures to control the microclimate include reducing the layers of pads underneath the individual as well as using clothing, incontinent briefs and coverings that are breathable (avoid plastic). It is important to monitor the skin hydration status to avoid excessive dryness that can also cause skin breakdown.

**A—ACTIVITY LEVELS:** Accumulating evidence suggests that people with restricted physical activities and restricted mobility are at risk for pressure ulcers. Norton and colleagues recently proposed that activity levels be considered when selecting a support surface. To optimize activities, clinicians must be aware that certain therapeutic support surfaces (e.g., foam, gel-filled and air-fluidized mattresses) tend to mold around body contours (envelopment) and allow the body to sink into the surface (immersion), compromising the person’s ability to get in and out of bed and his or her independence.

**T—TISSUE TOLERANCE:** Skin breakdown is inevitable when metabolic demand outstrips the supply of oxygen and vital nutrients. The extent and severity of tissue injury are, however, dependent on a number of intrinsic factors that predispose individuals to the development of pressure ulcers. Some of these key factors are poor nutritional intake, low body mass index (<18.5), hypoproteinemia, low systolic blood pressure, anemia, contractures and prominent bony prominences, vascular disease, neuropathy, and uncontrolled diabetes. Because pressure risk instruments do not address many of these factors, selection of support surfaces should be individualized, taking into consideration assessment of tissue tolerance to injury.

**T—TOTAL BODY WEIGHT:** Pressure and other mechanical forces compress, stretch and distort the normal alignment of the soft tissue, potentially leading to injury. The impact of mechanical distortion of the tissue is more pronounced in individuals who are emaciated. In one study, the maximum shear force at the coccyx was higher (p<0.01) in slender than in obese individuals when the head of the bed was raised from the supine position. On the other extreme of the body weight spectrum, bariatric individuals are also at high risk for pressure ulcer development due to the substantial stress that is put on the skin. Individuals with either high or low BMI should be carefully evaluated for a support surface that can prevent skin breakdown.

**R—REPOSITIONING NEEDS:** Although frequent repositioning is deemed essential to managing pressure, it is not always feasible in critically ill individuals, because positioning may precipitate vascular collapse or exacerbate shortness of breath (as with, e.g., advanced heart failure). A therapeutic surface is recommended for those who cannot tolerate either frequent repositioning or having the head of the bed lower than 30 degrees (due to dyspnea or in order to prevent aspiration during enteral feeding). The turning frequency can be reduced by the use of redistributing support surfaces; however, prolonged exposure to low pressure can be equally damaging to tissue. Clinicians must not forget there is a need for repositioning immaterial of the type of mattresses or specialty surfaces being utilized.

**E—EDEMA:** Edema, which stretches the skin and impairs the delivery of oxygen, is considered a risk factor for skin breakdown. By alternating air pressure in compartments of the mattress under the torso
and leg in a way that emulates the body’s natural intermittent movements, massage movements have been demonstrated to increase lymph flow that may aid edema management. However, alternating air mattresses must be used with caution; they can cause serious injuries in individuals with spinal instability and exacerbate symptoms such as motion sickness, protracted pain and nausea. Individualized assessment is warranted. Severe edema may lead to fluid leakage or “weeping” through the skin that may benefit from low air loss and air-fluidized support surfaces that draw moisture into the air to keep skin dry.

**S—SHEAR AND FRICTION:** Development of pressure ulcers is a dynamic and complex process that involves the combined effect of mechanical forces, including shear and friction, in addition to pressure. Pressure is defined as the perpendicular force that is applied to the skin, distorting and compressing underlying soft tissues, especially over bony prominences. Shear or shear stress is produced by displacement or deformation of tissue, usually in a diagonal direction, that alters the original alignment of tissue as one layer of tissue and the deeper structure slide in opposite directions (bony skeleton moving in an opposite direction to the surface skin). Deformation disrupts the cell structure, obstructs lymphatic drainage, reduces blood flow and potentiates ischemia.

In contrast, friction describes the resistance to movement created between two surfaces such as the superficial layers of skin and the adjoining support surface. By simply instituting measures to reduce friction, up to 16% of pressure ulcers can be prevented.

**S—SYMPTOM MANAGEMENT:** A support surface is often considered for individuals receiving palliative care to promote comfort. The primary purpose may not be pressure ulcer prevention but rather ensuring comfort at the end of life.

**E—EXISTING PRESSURE ULCER(S):** Individuals with an existing pressure ulcer are usually at risk for developing further skin breakdown. For those who have multiple ulcers, a support surface should be considered in order to address the lack of turning surfaces.

**S—SITES:** One of the areas that is most vulnerable to pressure-related skin damage is the heel. The heel has a pointed shape with a limited surface area of contact to redistribute pressure; when this is combined with the low subcutaneous tissue volume, this area is prone to pressure damage. Heel tissue is enveloped within the fibrous septa that allow pressure to build up easily and occlude vascular supply. Boots with the heel area cut out to allow the heel to be completely lifted off the surface are useful in preventing and treating pressure ulcers. Many different heel boots and positioning devices are available; however, no one device works best in all circumstances. Special attention must be paid to potential damage to the lower leg areas where the pressure is redistributed.

Health care professionals should determine the individual’s support surface needs by applying these selection principles to their assessment. The treatment goals can define an effective management strategy that addresses the therapeutic role of the support surface, whether it be primarily for prevention, symptom management, shear reduction or other wound care challenges.
VIEWPOINT ON SUPPORT SURFACES: THE LEGAL IMPLICATIONS

by Laurie Swezey, RN, BSN, CWOCN, CWS, FACCWS

According to the National Pressure Ulcer Advisory Panel, a support surface is “a specialized device for pressure redistribution designed for management of tissue loads, microclimate, and/or other therapeutic functions (i.e. any mattresses, integrated bed system, mattress replacement, overlay, or seat cushion, or seat cushion overlay).” Because there is no method available to provide weightlessness for our patients, the next best thing we can do to prevent skin breakdown is redistribute pressure on bony prominences as much as humanly possible.

Federal regulations (Medicare) state that individuals who have pressure ulcers, or who are at risk of developing pressure ulcers, must be afforded an appropriate support surface. Federal regulations also dictate which support surfaces may be used. Health organizations that fail to comply with these standards may be faced with both civil and criminal penalties. Federal regulations state that an individual who enters an institution or facility must be properly cared for in order to prevent pressure ulcers unless it can be shown that the pressure ulcers were an unavoidable consequence of the individual’s condition. In addition, the individual who enters an institution or facility and already has a pressure ulcer must be given appropriate treatment to heal the ulcer and prevent new pressure ulcers from forming, in addition to ensuring that the pressure ulcers do not become infected.

OFFERING SUPPORTIVE NUTRITIONAL CARE AT END OF LIFE

by Mary Ellen Posthauer, RD, CD, LD

While meeting the complex needs of individuals receiving palliative care, whether by providing pressure redistribution or by offering biotherapy to debride a necrotic wound, we must also address their simple need for nutrition. Food is a major part of our lives, with strong emotional and symbolic implications that encompass nurturing and traditions, as well as cultural, religious and social values. Nutrition and hydration have an effective role in healing wounds, but cannot prevent an individual with co-morbid conditions at the end of life from suffering or imminent death. This concept is often difficult to explain to the individual and especially to the caregivers who view nutrition and hydration as essential for life.

The goal of palliative care is, rather than curing, offering comfort while improving the quality of living and dying for those near the end of life. Clinicians should strives to maintain adequate nutrition and hydration that is compatible with the individual’s condition and wishes. As a member of the health care team, the dietitian should be involved in assessing the individual’s nutritional needs and educating the family and caregiver on nutrition expectations at the end of life.

Education and communication with families dealing with palliative care decisions is key to achieving a positive outcome of comfort and dignity for the individual. Practitioners should be sensitive to the cultural and/or religious beliefs that may influence how the individual or family views the end of life.
Family and caregiver interaction and socialization should be supported because it offers an actual or illusory source of strength, comfort and caring for the individual.

One of the many challenges facing dietetics practitioners is meeting the nutrition and hydration needs of the individual receiving palliative care. The 2009 NPUAP/EPUAP clinical practice guidelines addressed the issue of palliative care and nutrition. If the individual is alert and able to tolerate food and fluid, the following suggestions are recommended:

- Offer smaller meals of preferred food/fluid, regardless of the nutritional value.
- Relax or liberalize therapeutic diets (diabetic, sodium restricted, etc.) ordered to treat a medical condition.
- Explain to family and caregiver the rationale for liberalizing diet restrictions.
- Provide supplements of choice, if desired or tolerated.
- Keep water or fluid of choice at the bedside in a thermal container and encourage small, frequent sips.
- Avoid highly seasoned foods, unless requested.
- Offer comfort foods, gelatin, ice cream, popsicles, soups and ginger ale (may help with nausea).
- Educate the caregiver on appropriate feeding techniques (small bites or sips, never force-feed or feed an individual who is not alert or awake).
- Explain the dangers associated with choking or aspiration of food or fluid.
- Assess the oral cavity for lesions and offer frequent oral care to reduce pain and improve taste.
- Educate the caregiver about food safety issues (e.g., once opened, commercial supplements are perishable and should be chilled and discarded appropriately; wash raw vegetables and fruits prior to serving; keep serving area clean; discard uneaten food promptly).

When end of life is imminent, explain to the caregiver the benefit of lack of fluids or dehydration for the individual. Dehydration at end of life produces a natural anesthetic effect, decreases awareness, reduces urine output and may decrease pain. All palliative care interventions should reflect the individual’s choices and desires with the goal of retaining his or her comfort and the highest quality of life possible.

**CONCLUSION**

*by Aletha Tippett, MD*

The traditional goal of wound care is to heal or prepare for surgical closure, but techniques and procedures used to “heal” a wound can be painful or uncomfortable and very costly for an individual qualifying for palliative wound care. It is inappropriate to ignore wounds or declare them untreatable in individuals at the end of life even though that individual’s life span may not allow cure. Palliative wound care requires a mindset different from the traditional wound care mindset, yet is based on the same fundamental scientific principles.

It continues to be a challenge to successfully incorporate palliative care concepts into our existing health care system, which focuses so heavily on disease eradication. It is equally challenging to integrate palliative concepts throughout the continuum of wound care when the primary goal has always been
curative. Palliative wound care is the merging of symptom management into advanced wound care. Palliative care goals work in tandem with those aimed at complete wound closure, addressing objectives focused on quality-of-life issues for both the individual and the family. Palliative wound care is ideal for those wounds in which the underlying etiology does not respond to treatment or the demands of treatment are beyond the individual's tolerance or stamina.

The field of palliative wound care is emerging and has captured the interest of all who provide care for individuals who suffer with chronic wounds. Today, we know that palliative approaches to the care of wounds are simply the natural evolution of treatment options developed as a result of general advancements in modern medicine. Palliative principles introduced early into wound care provide individuals and their families options that maximize functional status, shifting the priorities from curative to palliative as the progressive nature of the disease demands.

In assessing an individual for palliative wound care, discuss his or her desires and needs. Determine the wound type. Consider interventions within your wound care strategy appropriate to the goals and needs of the individual. Carefully select a support surface to aid in the management of the individual's wound and also provide comfort. Provide supportive nutritional care. Offer compassionate care.

There is a great need for further education and training in this field. Readers who are interested are encouraged to visit www.hopeofhealing.org and register for the fourth annual Palliative Wound Care Conference, May 16–18, 2013, in Indianapolis, Indiana, the only wound conference devoted to palliative care.

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