1

PALLIATIVE WOUND CARE; DIGNITY IN THE DETAILS

Speakers:

- Vycki Nalls, PhD, GNP-BC, ACHPN, CWS
- Laura Berry White, MSN, APRN, FNP-BC, ACHPN, CWON

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DISCLOSURE OF FINANCIAL RELATIONSHIPS

- Neither of us do not have any relevant relationships to disclose.
- All photos used in this presentation have written consent or have been pulled from a free stock photo website.

3

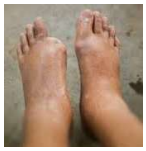
Learning Outcome

- At the end of this session, 95% of learners will report a change in their nursing practices related to wound assessments and how to determine when care should shift from curative to comfort-focused management.

4

Part 1: RECOGNIZING THE PATIENT SITUATION

"I know a guy" – JT 67 y/o male



- Recently readmitted to hospital for 3rd CHF exacerbation this year; known as a "frequent flyer" in the ED
- Comorbid conditions: Diabetes (A1C – 11.8), PVD
- PSH: L great toe amputation 2023
- JT struggles with:
  - Wearing compression dressings; often removes them
  - Taking diuretics – mobility impacts timeliness to restroom
  - Open/close/open of venous ulcers and/or maceration from BLE weeping
- Wound consult placed "again" this admission to assess BLE and make recommendations for his care (NOTE: usual routine recommendations not helping/working for this guy)

Could something be done differently?

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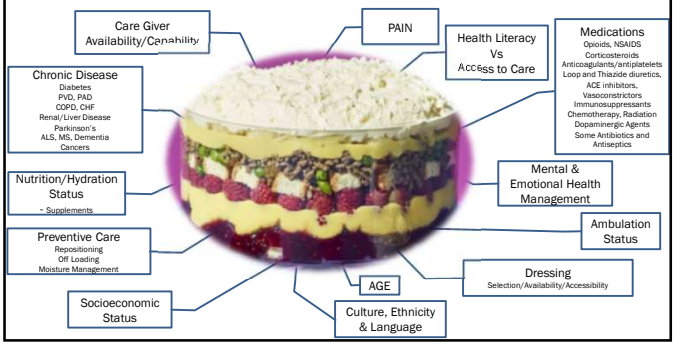
Is your patient layered with Barriers to Wound Healing?



6

Question For You…

Would you be surprised if JT died in the next 12 months?

Bruce vs. Tom

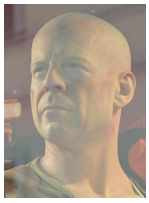


Image by darosky from Pixabay

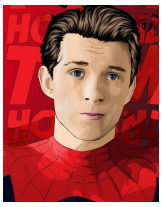


Image by Bùi Xuân Trường from Pixabay

Davis, M. P., & Vanenkevort, E. (2022). The surprise question. *BMJ Supportive & Palliative Care*, *12*(4), 403–406.
Chu, C., Engels, Y., Suh, S.-Y., Kim, S.-H., & White, N. (2023). Should the surprise question be used as a prognostic tool for people with life-limiting illnesses? *Journal of Pain and Symptom Management*, *66*(3), e437–e441.

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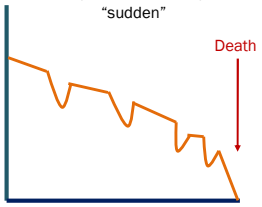
What If…

- JT shares he's tired of going to the hospital all the time
- He also shares he does not understand why his legs do not get better but hates the compression stockings
- JT's chart shows that he has advanced heart failure

Progressive illness (eg, heart failure); over few yrs but death may seem "sudden"



Adapted from Murray, et al. 2005 – Illness Trajectories & Palliative Care

Should JT be referred to hospice?

Murray SA, et al. *BMJ*. 2005;330(7498):1007–1011.

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Palliative vs. Hospice

Palliative Care	Hospice
Specialized medical care for people living with serious illness; focuses on symptom management and based on the needs of the patient, not the patient's prognosis.	Medicare definition – "program of care and support from people who are terminally ill and life expectancy is 6 months or less if the illness runs its normal course"
Any individual with a serious illness may receive, regardless of life expectancy or prognosis	Individual has a serious illness with predicted months to live
Individuals may still pursue curative treatment modalities	Curative treatment modalities are no longer beneficial
Services provided by an interdisciplinary team; collaborate with PCP and specialists through consultative services	Services provided by an interdisciplinary team; performed in collaboration with the attending physician
Refer to palliative care when someone is diagnosed with a life-limiting illness and needs symptom control, patient/family support	Refer to hospice if you'd answer "yes" to the surprise question: would you be surprised if this person died within the next 12 months?

Hospice Determining Terminal Status: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=34538
NHPCO: Palliative Care or Hospice? https://www.nhpco.org/wp-content/uploads/2019/04/PalliativeCare_VS_Hospice.pdf
CAPC: Palliative Care Referral Criteria https://www.capc.org/documents/download/286/

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A Quick Note About Hospice and Wound Care

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Hospice Election Statement

- Effective October 1, 2020 – patient or representative can request an addendum detailing non-covered items
- Is the patient's wound a part of the patient's overall PROGNOSIS (not diagnosis)
  - Ex: Patient has an ileostomy from ulcerative colitis, 24 years ago. They are now on services for dementia and presenting with increased behaviors; ripping off pouch & fiddling with bottom of pouch, creating an increase usage of pouches.
  - Patient is on services for Dementia that are not impacting prognosis and other areas of QOL.

A statement, although it would be rare, there could be some necessary items, drugs, or services, that will not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.

https://www.cms.gov/files/document/mm12015.pdf
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.24

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JT continues…

- When asked the surprise question, the clinical team acknowledges they would not be surprised if JT denied with in the next year
- JT does not yet meet hospice criteria for heart failure
- HOWEVER – he could benefit from palliative care, depending on his problematic symptoms, and he'd most likely benefit from **palliative wound care** because
  - His wounds are unlikely to heal given current situation and predicted future
  - He is declining and probably will qualify for hospice soon

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DEFINING PALLIATIVE WOUND CARE

"The goal of advanced wound caring must be to heal the person with a wound and to return that person to a productive and meaningful life." "The goals of advanced wound caring are to improve the outcomes and quality of life of those individuals suffering with chronic and complex wounds while reducing costs and providing comfort."

Advanced Wound Care

"Palliative wound care is the evolving body of knowledge and skills that take a holistic approach to relieving suffering and improving quality of life for patients and families living with chronic wounds, whether the wound is healable or not." – International Palliative Wound Care Initiative

Palliative Wound Care

"Even with limitations on wound healing, it is inappropriate to ignore wounds or declare them untreatable in individuals at end of life." – Dr. Tippett

Hospice Wound Care

Bohn, C.L., Collier, K.S., Protus, B. M., & Kimbrel, J.M. (2013). *Wound care at end of life: A guide for hospice professionals.* HospiScript Services.
Ferris, et al. (2007). Palliative wound care: managing chronic wounds across life's continuum: a consensus statement from the International Palliative Wound Care Initiative. *Journal of Palliative Medicine, 10*(1), 37–39.
Graves & Sun. (2013). Providing Quality Wound Care at the End of Life. *Journal of Hospice & Palliative Nursing, 15*(2), 66–74.
Tippett, et al. (2012, November 28). *Perspectives on Palliative Wound Care: Interprofessional Strategies for the Management of Palliative Wounds.* WoundSource. http://www.woundsource.com/whitepaper/perspectives-palliative-wound-care-interprofessional-strategies-management-palliative

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Advanced Wound Care vs Palliative Wound Care vs Hospice

	Advanced Wound Care	Palliative Care	Hospice
Who qualifies	-Anyone with a new or chronic wound that needs healing.	-Anyone with a serious illness, regardless of what stage in the disease process	-Anyone with a terminal illness that has been determined to have 6 months or less to live
Treatment provided to patient	-Symptom management -Curative and/or life-prolonging treatments -Chronic Disease mgmt. support -Assistance coordinating care -Advanced care planning	-Symptom management --Curative or life-prolonging treatments -Assistance coordinating care -Advance care planning	-Symptom management -Assistance coordinating care -End-of-life support -After death support
Where is it available	-Hospital setting, -Outpatient Setting -Sometimes within the home (nursing homes, long term care facilities)	-Hospital setting, -Outpatient Setting -Sometimes within the home	-"Home" (personal residence, LTC facility, group home, etc.), hospice facility, hospital
Who is the healthcare team	-Primary Care Provider and/or Specialty Provider	-Interdisciplinary team	-Interdisciplinary team
Wound care	-Advanced Wound Care Therapies -Advanced Dressing Selections Symptom -Targeted Treatment Modalities -Symptoms resolved or controlled *Focus on quality of life	-Dressing Selections -Symptom management -Minimizing infection -Focus on quality of life -Maintenance/Nonhealing wounds	-Dressing Selections -Symptom management -Minimizing infection -Focus on quality of life -Nonhealing/SCALE Wounds

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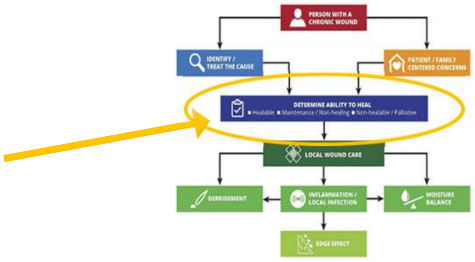
Part 2: ID'ing Potential Palliative Wounds

Wound Bed Paradigm



Sibbald, et al., (2021). Wound Bed Preparation 2021. *Advances in Skin & Wound Care,* 183-195.

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DETERMINING ABILITY TO HEAL

Healable
- Adequate blood supply to heal
- Cause of Wound Origin is/has being treated
- Can overcome barriers/layers to wound healing

Maintenance
- Adequate blood supply to heal
- Patient either: cannot or will not adhere to plan of care (Barriers/layers cannot be overcome)
- Healthcare system does not have appropriate resources

Non-healable
- Inadequate blood supply
- Cause of wound and/or barriers cannot be overcome

Sibbald, et al., (2021). Wound Bed Preparation 2021. *Advances in Skin & Wound Care*, 183-195.
Boersema, et al., (2021). Management of Nonhealable and Maintenance Wounds: A Systematic Integrative Review and Referral Pathway. *Advances in Skin & Wounds Care*, 11-22.

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III. Healing Probability Assessment Tool

FRAIL (For Recognition of Adult Immobilized Life)
Palliative Wound Care and Healing Probability Assessment Tool

Healing Probability Assessment Tool ©

The list below provides the foundation for estimating the probability for any skin wound to successfully respond to aggressive local intervention (including surgical closure) that seeks to close the wound(s). The more items checked on the list, the less likely the wound(s) will achieve a sustainable complete closure.

___Wound(s) over 3 months old, or is a reoccurrence of a pre-existing breakdown.
___Patient spends 20 or more hours a day in a dependent position (chair or bed)
___Patient is incontinent of urine
___Patient is incontinent of feces
___Patient has lost >5% of baseline weight, or 10 pounds, in the past 90 days.
Patient baseline weight: _____Actual weight: _____Date:_____
___Patient does not eat independently
___Patient does not walk independently
___Patient has a history of falls within last 90 days
___Patient is unable/unwilling to avoid placing weight over wound(s)/site(s)
___Wound is associated with complications of diabetes mellitus
___Wound is associated with peripheral vascular disease (PVD)
___Severe chronic obstructive pulmonary disease (COPD)
___End stage renal, liver, or heart disease
___Wound is associated with arterial disease
___Patient has diminished range of motion (ROM)
status non-responsive to rehabilitative services
___Patient has diminished level of mental alertness demonstrated by muted communication skills and inability to perform activities of daily living (ADLs) independently
___Wound is full thickness, with presence of tunneling
___Blood values indicate a low oxygen carrying capacity (Normal 13.5-17.5)
Patient hemoglobin: _____Date:_____
___Blood values indicate an exhausted or decreasing immune capacity (i.e., low lymphocyte count)
Patient TLC: _____Date:_____
___Blood values indicate below normal visceral protein levels that have not responded to nutritional support efforts
(i.e., low pre-albumin, transferrin, retinol- binding protein, and albumin)
Patient result: _____Date:_____

Score: _____/20 (Score = Total number of items checked)
The more items checked on the list, the less likely the wound(s) will achieve a sustainable complete closure.

Assessing Potential Palliative Wound Patient

Healing Probability Assessment Tool

**not reliable or validated by peer reviewed

It is a helpful flow sheet to use as a talking tool.

- Created by Alvarez and colleagues (2002)
- For long-term care facility or home care agency
- Estimates probability for wound to respond to aggressive local intervention (including surgical closure)
- More items checked, the less likely the wound(s) will achieve closure

https://s3.amazonaws.com/GentivaUniversity/JobAids/Tool+Box+Palliative+Wound+Care+Healing+Scale.pdf

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Types of Palliative Wounds – All Are Possible

Pressure Injuries
- most common wounds seen in hospice
  - 40-68% of hospice patients
  - 13-47% for palliative care patients
- 2022: NPIAP 2022 PI Incidence Statistics:
  - 2nd most common diagnosis (in health system billing record)
  - 20-30% average indecent across SNF

Skin Tears
- In palliative care: 3.3–14.3%

Malignant Wounds
- 3rd most prevalent in palliative care/hospice
- Affecting 5-14% of patients with advanced cancer
  - Breast: 66%
  - Head & neck: 24%
  - Groin, genitals & back: 3%
  - Other sites: 8%

Other common palliative wounds:
- arterial/gangrene, venous, autoimmune-related wounds, atypical, and "skin failure" (more to come on this one…)

Walsh, A. (2021). Palliative Wound Care: Case studies. *Journal of Hospice & Palliative Nursing, 24*(1): 15-21.
Artico, M., Dante, A., D'Angelo, D., Lamarca, L., Mastroianni, C., Petitti, T., Pireddu, M., & De Marinis, M. G. (2018). Prevalence, incidence and associated factors of pressure ulcers in home palliative care patients: A retrospective chart review. *Palliative Medicine, 32*(1), 299–307.

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Palliative Wound Care: What Kind of Care do Patients Receive?

Preventive

A Text-Book of Nursing; 3rd edition circa 1903:

"Bed sores…They are more easily prevented than cured…preventive measures consist in keeping the parts thoroughly clean, and the surface under them dry and smooth, and in relieving so far as possible the local pressure. ***This precautionary treatment should be commenced at the beginning of any long sickness, without waiting for manifest signs of danger."***

- Standards of care still apply
- QOL and symptom management approach are implemented
- Communication with patient and caregivers is KEY

Lucena, PLC, et al. 2021. *Scientific Evidence on Interventions for Palliative Care Patients with a Wound: A scoping review.* https://doi.org/10.9789/2175-5361.rpcfo.v12.9467

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PALLIATIVE WOUND CARE FRAMEWORKS:

Pivoting to Managing Symptoms
S.P.E.C.I.A.L. & H.O.P.P.E.S.

- S = stabilize the wound
- P = prevent new wounds
- E = eliminate odor
- C = control pain
- I = infection prophylaxis
- A = absorbent wound dressings
- L = less/reduce dressing changes

Wendelken, et al. (2009, June 29). Case Studies In Palliative Wound Care | Podiatry Today. https://www.podiatrytoday.com/case-studies-in-palliative-wound-care

- H = hemorrhage
- O = odor control
- P = pain
- P = pruritus
- E = exudate management
- S = superficial infection

Woo, K. (2017). HOPES for palliative wounds. International Journal of Palliative Nursing, 23(6), 264–268.

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Part 3: Talking About Goals - VitalTalk

G.U.I.D.E. or A.D.A.P.T.

GUIDE: delivering (serious) news

- G = GET READY
- U = UNDERSTAND
- I = INFORM
- D = DEEPEN
- E = EQUIP

ADAPT: discuss (wound) prognosis

- A = ASK
- D = DISCOVER
- A = ANTICIPATE
- P = PROVIDE
- T = TRACK

Vital Talk. Published 2019. Accessed April 6, 2026: https://vitaltalk.org/discussing-prognosis/
Vital Talk. Published 2019. Accessed April 6, 2026: https://vitaltalk.org/serious-news/

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Slide 19

VN1 Need this reference
Vycki Nalls, 2026-04-06T23:51:21.251

VITAL talk – ADAPT Tool for Prognosis

- ***A**sk what the patient knows*
  - Ex: What do you understand about your lower extremity ulcers/wounds?
  - Open ended questions, or targeted questions to get direct answers.
- ***D**iscover what information (about the future) that would be useful for the patient*
  - Some may prefer statistics, to talk through the "usual", etc. (analytical)
  - Others may be looking to live to a goal or specific date (synthetical)
- ***A**nticipate ambivalence*
  - Check to see how much the patient/care givers have absorbed regarding what you are discussing, feedback
  - Share with them feelings/emotions you may be picking up on or ask them about theirs.
- ***P**rovide information in the form the patient wants*
  - Ties to above; do they want statistics, "healing for this type of lower extremity ulcer with your comorbid conditions of diabetes and PVD is X%" or more general, "unlikely to heal, delayed healing expected" and tying in current functionality and barriers to wound healing
- ***T**rack emotion*
  - "I wish I had better or different news". "I can see this is not what you were hoping for."
  - "What The Palliative Care Team is here to support you and your care givers.

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VITAL talk – GUIDE Tool for Delivering News

- ***G**et Ready*
  - Get ready before you sit down, know what the you are going to be talking about, choose a comfortable setting
  - It's ok to review your own emotions and how you are responding to getting ready to delivering this news/information
- ***U**nderstand*
  - Understand/Learn what your patient has heard before you start sharing
  - "What have you heard from other providers?"
- ***I**nform*
  - Inform or Disclose using a one-sentence headline
  - "This Bed Sore may not be healable" NOT "Healing this wound may be difficult based on XYZ.
- ***D**eepen*
  - Your connection by responding to emotions.
  - Don't fill the silence
- ***E**quip*
  - Your patient and care givers for the nest steps in care as you end the conversation
    - Summarize, Explain or Teach Back
    - What are our 1,2,3 next goals till our next conversation

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Part 4: Case Studies

Our Words/Tools in Action – Applying to Everyday Practice

- 4 Case Studies
  - Hemorrhage: Skin Tear
  - Odor: Fungating Tumor
  - Pain: Pressure Injury
  - Exudate (and pruritus): JT, our patient with weeping & itching BLEs

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H: Hemorrhage (Bleeding) & Skin tears

- MH is a 62 y/o Asian Male, lives at home with extended family
- Followed by Palliative Care for Parkinson's Disease (PD)
- PMH: HTN, HLD, GERD, PD related Dementia
- Medications: thiazide diuretic, PRN loop diuretic, statin, PPI, PRN NSAIDS, dopaminergic agents
- Recent fall at home while pivoting to commode from recliner.
- Consult placed for skins tears that continue to BLEED.
- Functional ability: Independent with pivoting from same plain surfaces (ex: bed to commode) and independent with eating but dependent on food prep. (Family very involved in ADLs)
- Neighbor recommended Turmeric (based on cultural background); family has been applying from kitchen cabinet.

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Managing Symptoms: Hemorrhage VN1

Antifibrinolytic Agent	Sclerosing Agent	Chitosan (hydrofibers, gels)	Oxidized Cellulose	Oxymetazoline
• Off label IV dosing used topically • Topically it can help to cause thrombin clots • Aminocaproic acid: 250mg/ml • Tranexamic acid: 500mg/5ml-10ml QID PRN • Also comes in mouthwash suspension.	• Silver Nitrate Sticks • Moistening the tip sparks a chemical reaction (chemical debriding agent) that burns organic matter, coagulates tissue and destroys bacteria.	• Hemostatic dressing that adheres to red blood cells and encourages platelets to adhere, activate, and aggregate at the site of injury.	• Hemostatic agent made of an oxidized cellulose polymer, used primarily in acute injury involving: • Sutures, staple, surgery. • Should be left on to form a clot. • *NOT FOR TUMORS*	• Stimulates blood vessels to constrict, primarily works best when smooth muscle fibers exposed. • Minor bleeds • Apply pressure with application

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GUIDE: Hemorrhage & Skin Tear

- ***G**et Ready*
  - Reviewed chart, discussed with provider placing consult what happened with fall and where patient is at with life trajectory, and where in disease process. Asked where in the home, prior to getting there, where most conversations happen.
  - Reflected on how there will be many family members of various ages.
  - Touched based with LICSW on any culture customs or perceived "barriers" I should know
  - Is interpreter needed? (for patient and wife, son and daughter could speak and write in English)
- ***U**nderstand*
  - Using interpreter, asked family for history of event (fall), and how they are coping.
  - Asked them what they have been doing for wound care, prior to my arrival.
    - Their neighbor is Indian and recommended Turmeric and Non-adherent pads- that where sticking
- ***I**nform*
  - Inform or Disclose using a one-sentence headline to son of patient.
  - "To heal these, we may need to use a different dressing approach".
- ***D**eepen*
  - Waited for this sentence to be processed and answered son's questions.
  - Asked son if any other family members had any questions, to which he did ask his mother and sister.
- ***E**quip*
  - Reviewed a new dressing plan and rationale
  - Discussed barriers to wound healing (medications, decreased mobility) and wounds would be slow to heal.
  - Did a teach back, where I taught wife, and daughter dressing by talking them through it.

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Slide 26

VN1 Need references
Vycki Nalls, 2026-04-07T00:00:47.965

Hemorrhage:

What was done?

- Stopped Turmeric
  - can help reduce healing time and reduce scarring.
  - used in neuropathic ulcers, snake bites, C-section scars.
  - Not skin tears.
  - Not for Bleeding wounds.
- Cleansed with Wound Care Cleanser and Gauze
- Applied 2-3 squirts of Oxymetazoline
  - to wound bed at time of dressing change PRN bleeding
- Applied a silicone mesh non-contact layer
- Applied a Chitosan Impregnated Hydrofiber
- Covered with an absorbent polymer core dressing
- Changed 2 times a week and PRN

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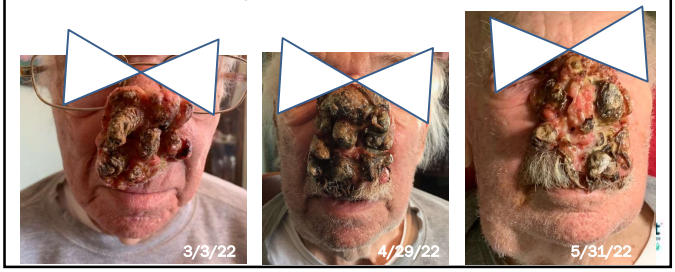
O: Odor & Malignant fungating tumor: BCC

Mr. BK is an 83y/o male, living at home who transitioned from Pall Care to Hospice Services
Wound Consult placed for BCC to the nose.
Main concern: Odor (overpowering for people to enter home to provide care).



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Managing Symptoms: Odor, topical agents

Metronidazole	Silver	Charcoal or Carbon Dressings	Antiseptics	*Environmental Adjustments
• *Not FDA approved • **250mg Tablets** • 1% paste • 1% solution • 5% powder • 0.75, 0.8%, 1% metrogel	• Alginate • Hydrofiber • Foam • Gel • Inhibit bacterial growth	• Activated charcoal absorbs bacteria and localized wound toxins • Charcoal: Comes as a packaged layered dressing • Do NOT cut • Carbon: can come in a foam like cloth dressing • Often combined with an antimicrobial agent	• Sodium Hypochlorite Solution (0.125%) • Hypochlorous Acid • Iodine/Povidone-Iodine • (wipe/swab) • Dry eschar ONLY • Acetic Acid 0.25%	• Kitty Litter • Coffee Grounds • Scents patient would like: • Candles • Air Freshener's

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ADAPT: Odor & Fungating Tumor

- *Ask what the patient knows*
  - What do you understand about your nose wound?
    - Patient understood it was cancer, and nonhealing, and would get worse.
- *Discover what information (about the future) that would be useful for the patient*
  - Analytical vs **Synthetical**
    - He had no future goals, except to maintain independence for as long as possible, and when he couldn't to go to the hospice house to pass.
- *Anticipate ambivalence*
  - How much the patient absorbed regarding what you are discussing, patient openly shared emotions
    - His feelings were about his neighbors and family visiting and being frightened by his appearance or turned off by the odor. And he had pain, like an itch/burning sensation where the tumor meets the skin.
- *Provide information in the form the patient wants*
  - Analytical vs **Synthetical**
    - Patient wanted written and tutorial steps on performing own wound care, this was given to him. And daughter video taped tutorial so he could study it more, before applying wound care to himself.
- *Track emotion*
  - Primary Nurse coached and assisted in mirroring or shadowing patient's disposition, be it a cheery day or a frustrated day, verbalizing it back to patient.
    - Multiple visits with patient, as wound evolved and plan of care needed to change.
    - Patient continuously verbalized appreciation of his input and participation, and autonomy.

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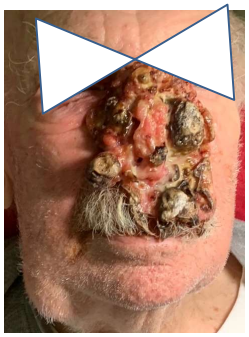

Odor:

What was done?

- No sense of smell.
- Cleaned with ¼ sodium hypochlorite that was placed (by pharmacy) into an appropriate PSI squirt bottle
- Metronidazole tablets were crushed with sterile water added to make a paste, that was then applied via Q-tip
- Silver alginate cut to fit and 2x2 gauze, that we held in place with a surgical mask folded in half.
  - Patient could still then access mouth
- Changed almost daily by nurse, daughter, or sometimes patient

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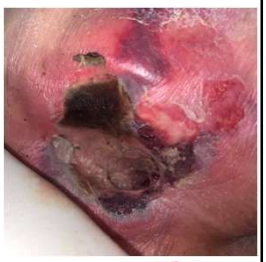
P: Pain & Pressure Injury

- IB is a 94 y/o Caucasian Female SNF resident
- Hospice is following for additional supportive care related to Alzheimer's Dementia
- PMH: osteoporosis
- Medications: Vitamin D, calcium
- Hospice nurse arrives Monday morning and finds patient in a transitional phase to actively dying; no PO intake all weekend, and a new pressure injury reported – described as rapidly developing/worsening over the weekend
- Pt with foley catheter, incontinent of stool.
- Ordered over the weekend; Collagenase, gauze and border foam, changing QD to BID
- Reporting concern of pain, as patient is grimacing & moaning



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Managing Pain Symptoms: Topical Agents

Lidocaine & Prilocaine Topical Cream	Lidocaine Patch	Lidocaine Gel/Ointment Cream, Lotion	Morphine	Ketamine
• Combination of lidocaine 2.5% and prilocaine 2.5% • Apply peri wound 20min before debridement or dressing application • Little concern for nervous system toxicity. • Analgesic and anesthetic effect.	• 5% • To periwound area • Change with dressing change. • Daily Dressing change • Analgesic effect	• 2%, 4% or 5%: half-life is approx. 20-60mins. • This can be applied multiple times through out the day to the area, PRN.	• 5mg/1ml, 10mg/1ml 20mg/1ml • Long acting, half life 8-12 hours, • QD to BID • Local Analgesic effect, rapid relief • Apply: shallow, low-moderate draining, pink to red wound beds. • NOT PRN • Can come in spray or gel form	• Mgmt. for neuropathic pain • 30g jar of 15% ketamine w/ 15% lidocaine cream • 30ml bottle of 5-10% ketamine spray mixed with 1% lidocaine and 5% morphine • Spray applied to entire wound bed

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GUIDE: Pressure Injury, Sacrum

- ***G**et Ready*
  - Review chart talk with clinical staff, to find out what happened over the weekend; medication management, what are my measuring tool numbers, may be reviewing patient status using the probably healing tool assessment.
  - Learn about patient
  - Review my feelings and how I talk through my data and my presentation with myself
  - Suggest family meets in a conference room and then we walk to the patient's bedside, vs all cramming into the patient's room with a shared room-mate.
- ***U**nderstand*
  - Understand/Learn where the family and caregivers are and what they understand and know about the patient/situation before I share medical opinion and news.
  - Facility staff continued to use term of "Kennedy".
  - Family did not understand why a president was being referred to in conversation.
- ***I**nform*
  - Inform or Disclose using a one-sentence headline
  - "This Bed Sore may not be healable"
- ***D**eepen*
  - Waiting out the awkward silence.
  - Chip away at questions. By supplying information and data collected on patient's layers to their barriers to heal
    - Poor PO intake, immobility, change in overall status with active signs of a transitional phase
- ***E**quip*
  - Summarize conversation at end, and leave Care Givers with goals;
    - pain management, new palliative-hospice wound care recommendations

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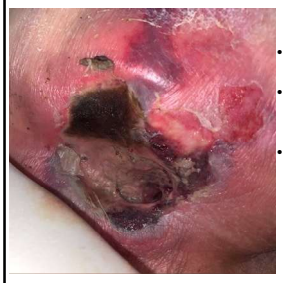

Pain:

What was done?

- We did not actually do topical Pain management because….
- Patient was placed on systemic ATC and PRN
  - Morphine, Lorazepam and Haloperidol for CMO
- Wound Care, changed to:
  - Clean with wound care and gauze, skin prep to peri wound, metronidazole crushed 250mg tab x2-3 pills to wound bed
  - If facility does not permit metronidazole use, recommend; 5% compounded powder
  - Lay large ABD pad over wound
  - Utilize brief as part of dressing and change BID due to drainage

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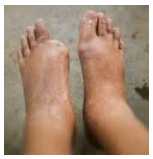
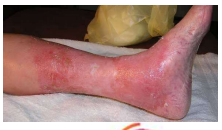
Pruritus & Exudate: BLE

Back to our initial patient JT:

- 67y/o m
- Recently readmitted to hospital for CHF exacerbation, complaints of BLE edema, itchy, weeping legs, history of venous ulcers.
- He was recently hospitalized 22 day ago for CHF exacerbation and treatment of BLEs.
- JT struggles with:
  - Wearing compression dressings, often choosing to remove them.
  - Taking diuretics, poor mobility to get to bathroom
- Comorbidity of Diabetes; last a1c 11.8, history of a Great Left Toe Amp, 3y ago.





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Managing Symptoms: Exudate and Pruritis

establish probable cause

Polymer Core Absorbent Dressings	Aqua/Hydro Absorbent Dressings	BLE Compression	Topical "Itch"	Systemic "Itch"
• Fluid repellent backing • Vicks vertically • Moderate to High drainage • Retains high volumes • Polyacrylate particles that create the super absorbance	• Draws exudate away from the wound • Absorbs excessive exudate • Porous structure	Does not maintain • Elastic Compression Wraps Light to moderate • Elastic Tubular support bandage Mod to High • 2 Layer Wraps • 4 Layer Wraps	• Reactions from • topical agents, irritants • Dry Skin • Tx: • Camphor 0.5% & Menthol 0.5% topical lotion • Topical Steroids • Emollients • Remove irritant	• Reactions from • Oral meds • Disease process • High Bili • Liver disease • Uremia • ESRD • COPD • Tx: • PO Steroids • PO Anti-itch medications • Antihistamines • Gaba receptor

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ADAPT: BLE Exudate and Pruritus

- ***A**sk what the patient knows*
  - Direct closed ended questions used in gentle manner, as patient loved to talk.
  - JT was very aware of his CHF exacerbations, and his dislike of diuretics and compression therapy. He verbalized he understood not taking medications or utilize therapies would result in worsening edema, weeping and itching.
- ***D**iscover what information (about the future) that would be useful for the patient*
  - Again, synthetical. Did not want to talk about risk of death after amputation, risk of more amputations, did not want to talk about pro/cons. Wanted to focus on what can we do "instead"
- ***A**nticipate ambivalence*
  - Discussed how patient appeared very "I give up" and what he wanted out of life and where to go from here.
- ***P**rovide information in the form the patient wants*
  - Patient wanted to learn how he could just stay home in his recliner, watching his shows. Discussion on ways to do that was provided: example VNA vs hiring home health aides, vs seeing what aid was available in the community, vs hospice.
- ***T**rack emotion*
  - Reflected back and asked him what he thought and felt about moving forward with various options and what fears or barriers he maybe had about working with the options provided.

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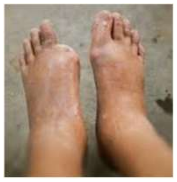
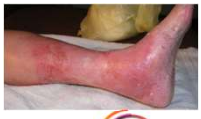
Exudate & Pruritus

What was done?





- JT – referred to Palliative Care while in hospital
- Shortly after, qualifies for hospice and community resources
  - Home delivered meal service was also started, with low NA diet
- When admitted onto hospice:
  - Nurse performs wound care MWF: wash legs, apply barrier creams, and polymer core dressings with gauze wrap + elastic compression wraps.
  - Patient set up with nurse assistant for M-F bathing
  - Urinal/commode next to recliner
  - PO diuretic continued
  - No more hospitalizations; comfort care managed at home

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Part 5: The Grey Area and Great Debate

- Skin Failure/ End-of-life (EOL) Wound
  - Latimer and colleagues (2022) integrative review
    - Multiple names: terminal ulcer (TU), Kennedy Ulcer, Trombley-Brennan terminal tissue injury (TB-TTI), etc.
    - Notable feature of TUs: sudden/rapid onset, location usually sacrum, pear or butterfly-shaped, rapid/continual expansion in size of ulcer
    - Dearth of evidence to inform clinical practice
  - NPIAP (2025) Think Tank
    - Concluded that skin failure in critically ill adults should be considered non-pressure related
    - Skin failure = injury that occurs despite standard preventive interventions for which no other etiology has been ID'd
- Unavoidable Pressure Injury:
  - Diagnosis by exclusion – implemented and documented that all standards of wound care have been followed, yet a pressure injury still developed
  - Levine (2026) Review article
    - Growing evidence supports the concept that wounds can develop despite optimal preventative measures, most often in patients with multimorbidity or limited physiological reserve

Black, et. al. *JWOCN.* 2025; 52(5):369-375. Latimer S, et al. *Adv Skin Wound Care.* 2022;35(4):225-233.
Schmitt S, et al. *J Wound Ostomy Continence Nurs.* 2017;44(5):458-468. Levine, J. *Intern'l Wound Journal.* 2026. 23(2):e70851.

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How Do We Know in Clinical Practice?

Research is hard, no real standardized assessment approach to skin failure

- Hard to predict who will develop and who will not develop skin failure
- Reliant on retrospective studies, case studies, and expert opinion
- Finding consistent documentation for retrospective studies is hard
  - no standard ICD-10 code for diagnosis
  - No established consensus of what is skin failure
  - Hard for clinicians to identify EOL wounds/skin failure
- Attempts to improve research that can then be translated into clinical practice:
  - Latimer and colleagues' tool
  - PAWSIC-AADA ICD-10 code proposal

Black, et. al. *JWOCN.* 2025; 52(5):369-375. Levine, *J. Intern'l Wound Journal.* 2026. 23(2):e70851.
Latimer, et al. *BMC Pall Care.* 2025; 24(1): 216-227.

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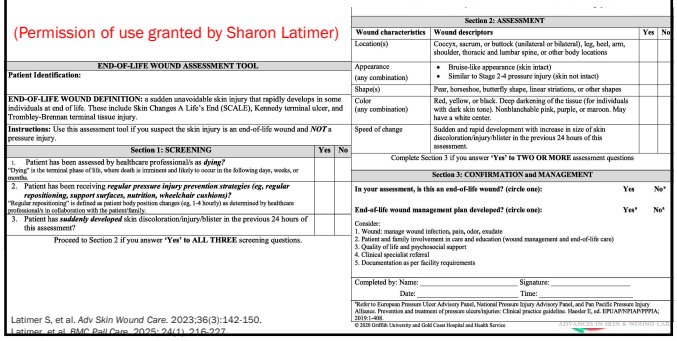
Wound Assessment Tool for EOL Wounds

(Permission of use granted by Sharon Latimer)



END-OF-LIFE WOUND ASSESSMENT TOOL

Patient Identification:

END-OF-LIFE WOUND DEFINITION: a sudden unavoidable skin injury that rapidly develops in some individuals at end of life. Those include Skin Changes At Life's End (SCALE), Kennedy terminal ulcer, and Trombley-Brennan terminal tissue injury.

Instructions: Use this assessment tool if you suspect the skin injury is an end-of-life wound and ***NOT*** a pressure injury.

Section 1: SCREENING	Yes	No
1. Patient has been assessed by healthcare professional/s as ***dying?*** "Dying" is the terminal phase of life, where death is imminent and likely to occur in the following days, weeks, or months.		
2. Patient has been receiving ***regular pressure injury prevention strategies (eg, regular repositioning, support surfaces, nutrition, wheelchair cushions)?*** "Regular repositioning" is defined as patient body position changes (eg, 1-4 hourly) as determined by healthcare professional/s in collaboration with the patient/family.		
3. Patient has ***suddenly developed*** skin discoloration/injury/blister in the previous 24 hours of this assessment?		

Proceed to Section 2 if you answer **'Yes' to ALL THREE** screening questions.

Section 2: ASSESSMENT			
Wound characteristics	**Wound descriptors**	**Yes**	**No**
Location(s)	Coccyx, sacrum, or buttock (unilateral or bilateral), leg, heel, arm, shoulder, thoracic and lumbar spine, or other body locations		
Appearance (any combination)	• Bruise-like appearance (skin intact) • Similar to Stage 2-4 pressure injury (skin not intact)		
Shape(s)	Pear, horseshoe, butterfly shape, linear striations, or other shapes		
Color (any combination)	Red, yellow, or black. Deep darkening of the tissue (for individuals with dark skin tone). Nonblanchable pink, purple, or maroon. May have a white center.		
Speed of change	Sudden and rapid development with increase in size of skin discoloration/injury/blister in the previous 24 hours of this assessment.		

Complete Section 3 if you answer **'Yes' to TWO OR MORE** assessment questions

Section 3: CONFIRMATION and MANAGEMENT

In your assessment, is this an end-of-life wound? (circle one): **Yes** **No***

End-of-life wound management plan developed? (circle one): **Yes*** **No***

Consider:
1. Wound: manage wound infection, pain, odor, exudate
2. Patient and family involvement in care and education (wound management and end-of-life care)
3. Quality of life and psychosocial support
4. Clinical specialist referral
5. Documentation as per facility requirements

Completed by: Name: _____ Signature: _____

Date: _____ Time: _____

*Refer to European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel, and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers/injuries: Clinical practice guideline. Haesler E, ed. EPUAP/NPIAP/PPPIA; 2019:1-498.

Latimer S, et al. *Adv Skin Wound Care.* 2023;36(3):142-150.
Latimer, et al. *BMC Pall Care.* 2025; 24(1): 216-227.

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AADA-PAWSIC ICD-10 Code Proposal

- Current codes used for EOL Wounds/Skin Failure
  - L98 Other disorders of skin and subcutaneous tissue, not elsewhere classified
  - L98.8 Other specified disorders of the skin and subcutaneous tissue
- Proposed Codes
  - L98.80 – Skin changes d/t skin failure – exclusions listed in proposal and requirement to code underlying condition
  - Additional sub-subcategory codes also proposed for acute, chronic, and end-stage skin changes due to skin failure
- Work in progress if it will go into effect

AADA-PAWSIC Skin Failure Code Proposal for Tabular Modification Latest submission to the ICD-10-CM Committee September 9, 2025

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In Summary

- Hospice is a type of palliative care
- Those receiving palliative care can still be on a curative pathway.
- Palliative wound care is shifting the primary focus from closure to symptom management; however, palliative wound care does NOT mean we stop preventative measures or stop following the standards of wound care.
- Wound clinicians are a part of the interdisciplinary team caring for individuals with progressive illness; all of us need to communicate effectively with patients, caregivers and each other.
- When the patient moves to a more palliative wound care management approach, remember to shift your thoughts:

What's the matter with this patient and their wound?
TO
What matters to this patient about their wound?

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