Dealing with the end of a loved one’s life is difficult enough, but when wound and skin care issues are involved, the decisions about how to manage the patient can be even more challenging. The European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP) have added a new section on palliative care to their pressure ulcer treatment guide to help clinicians navigate through some of these difficult treatment decisions.

Pressure Ulcer Treatment: Quick Reference Guide now includes a section on “Pressure Ulcer Management in Individuals Receiving Palliative Care,” which is reproduced on the following pages for your reference. The palliative care perspective is woven throughout, showing how to focus treatment decisions on maintaining the patient’s comfort in terms of pressure redistribution, nutrition and hydration, skin care, pain assessment and management and resource assessment.

Clinicians caring for terminal patients with pressure ulcers will find this resource tremendously helpful.
Pressure Ulcer Management in Individuals Receiving Palliative Care Patient and Risk Assessment

Assessment

1. Complete a comprehensive assessment of the individual. (Strength of Evidence = C)
2. Assess the risk for new pressure ulcer development on a regular basis by using a structured, consistent approach which includes a validated risk assessment tool and a comprehensive skin assessment, refined by using clinical judgment informed by key risk factors (see Risk Assessment section). (Strength of Evidence = C)

2.1. Use a general screening tool such as the Braden Scale, Norton Scale, Waterlow Scale, Braden Q (for pediatric patients), or other age-appropriate tool in conjunction with clinical judgment. (Strength of Evidence = C)
2.2. Use the Marie Curie Centre Hunters Hill Risk Assessment Tool, specific to individuals in palliative care, in conjunction with clinical judgment for an adult individual. (Strength of Evidence = C)

Pressure Redistribution

1. Reposition and turn the individual at periodic intervals, in accordance with the individual’s wishes and tolerance. (Strength of Evidence = C)
1.1. Establish a flexible repositioning schedule based on individual preferences and tolerance and the pressure-redistribution characteristics of the support surface. (Strength of Evidence = C)
1.2. Pre-medicate the individual 20 to 30 minutes prior to a scheduled position change for individuals who experience significant pain on movement. (Strength of Evidence = C)
1.3. Observe the individual’s choices in turning, including whether she/he has a “position of comfort,” after explaining the rationale for turning. (Strength of Evidence = C)
1.4. Comfort is of primary importance and may supersede prevention and wound care for individuals who are actively dying or have conditions causing them to have a single position of comfort. (Strength of Evidence = C)
1.5. Consider changing the support surface to improve pressure redistribution and comfort. (Strength of Evidence = C)
1.6. Strive to reposition an individual receiving palliative care at least every 4 hours on a pressure-distributing mattress such as viscoelastic foam, or every 2 hours on a regular mattress. (Strength of Evidence = B)
1.7. Individualize the turning and repositioning schedule, ensuring that it is consistent with the individual’s goals and wishes, current clinical status, and combination of co-morbid conditions, as medically feasible. (Strength of Evidence = C)
1.8. Document turning and repositioning, as well as the factors influencing these decisions (e.g., individual wishes or medical needs). (Strength of Evidence = C)
2. Consider the following factors in repositioning:
2.1. Protect the sacrum, elbows, and greater trochanters, which are particularly vulnerable to pressure. (Strength of Evidence = C)
2.2. Use positioning devices such as foam or pillows, as necessary to prevent direct contact of bony prominences and to avoid having the individual lie directly on the pressure ulcer (unless this is the position of least discomfort, per individual preference). (Strength of Evidence = C)
2.3. Use heel protectors and/or suspend the length of the leg over a pillow or folded blanket to float the heels. (Strength of Evidence = C)
2.4. Use a chair cushion that redistributes pressure on the bony prominences and increases comfort for an individual who is seated. (Strength of Evidence = C)

Source:
Nutrition and Hydration

1. Strive to maintain adequate nutrition and hydration compatible with the individual's condition and wishes. Adequate nutritional support is often not attainable when the individual is unable or refuses to eat, based on certain disease states. (Strength of Evidence = C)
2. Allow the individual to ingest fluids and foods of choice. (Strength of Evidence = C)
3. Offer several small meals per day. (Strength of Evidence = C)
4. Offer nutritional protein supplements when ulcer healing is the goal. (Strength of Evidence = C)

Skin Care

1. Maintain skin integrity to the extent possible. (Strength of Evidence = C)
1.1. Apply skin emollients per manufacturer's directions to maintain adequate skin moisture and prevent dryness. (Strength of Evidence = C)
1.2. Minimize the potential adverse effects of incontinence on skin. See Prevention section.
Pressure Ulcer Care

Pain management, odor control, and exudate control are the aspects of pressure ulcer care that tend to be most closely related to supporting the individual's comfort.

1. Set treatment goals consistent with the values and goals of the individual, while considering family input. (Strength of Evidence = C)

   1.1. Set a goal to enhance quality of life, even if the pressure ulcer cannot be healed or treatment does not lead to closure/healing. (Strength of Evidence = C)

2. Assess the pressure ulcer initially and with each dressing change, but at least weekly (unless the individual is actively dying), and document findings. (Strength of Evidence = C)

2.1. See Assessment and Monitoring Healing section for general assessment information.

2.2. Monitor the ulcer in order to continue to meet the goals of comfort and reduction in wound pain, addressing wound symptoms such as odor and exudate. (Strength of Evidence = C)

3. Manage the pressure ulcer and periwound area on a regular basis as consistent with the individual's wishes. (Strength of Evidence = C)

3.1. Cleanse the wound with each dressing change using potable water (i.e., water suitable for drinking), normal saline, or a noncytotoxic cleanser to minimize trauma to the wound and help control odor. (Strength of Evidence = C)

3.2. Debride the ulcer of devitalized tissue to control infection and odor. (Strength of Evidence = C)

3.2.1. Debride devitalized tissue within the wound bed or at edges of pressure ulcers when appropriate to the individual's condition and consistent with the overall goals of care. (Strength of Evidence = C)

3.2.2. Avoid sharp debridement with fragile tissue that bleeds easily. (Strength of Evidence = C)

3.3. Choose a dressing that can absorb the amount of exudate present, control odor, keep periwound skin dry, and prevent desiccation of the ulcer. (Strength of Evidence = C)

3.3.1. Use a dressing that maintains a moist wound-healing environment and is comfortable for the individual. (Strength of Evidence = C)

3.3.2. Use dressings than can remain in place for longer periods of time to promote comfort related to the pressure ulcer care. (Strength of Evidence = C)

3.3.3. Use a dressing that meets the needs of the individual for overall comfort and pressure ulcer care. See section on Dressings. (Strength of Evidence = C)

3.3.3.1. Consider use of an antimicrobial dressing to control bioburden and odor. (Strength of Evidence = C)

3.3.3.2. Consider use of a hydrogel to soothe the painful ulcers. (Strength of Evidence = C)

3.3.3.3. Consider use of foam and alginate dressings to control heavy exudate and lengthen wear time. (Strength of Evidence = B)

3.3.3.4. Consider use of polymeric membrane foam for exudate control and cleansing. (Strength of Evidence = C)

3.3.3.5. Consider use of silicone dressings to reduce pain with dressing removal. (Strength of Evidence = B)

3.3.4. Protect the periwound skin with a skin protectant/barrier or dressing. (Strength of Evidence = C)

4. Control wound odor. (Strength of Evidence = C)

4.1. Cleanse the ulcer and periwound tissue, using care to remove devitalized tissue. (Strength of Evidence = C)

4.2. Assess the ulcer for signs of wound infection: increasing pain; friable, edematous, pale, dusky granulation tissue; foul odor and wound breakdown; pocketing at base; or delayed healing. (Strength of Evidence = B)

4.3. Use antimicrobial agents as appropriate to control known infection and suspected critical colonization. See Infection section. (Strength of Evidence = C)

4.3.1. Consider use of properly diluted antiseptic solutions for limited periods of time to control odor. (Strength of Evidence = C)

4.3.2. Consider use of topical metronidazole to effectively control pressure ulcer odor associated with anaerobic bacteria and protozoal infections. (Strength of Evidence = C)

4.3.3. Consider use of dressings impregnated with antimicrobial agents (e.g., silver, cadexomer iodine, medical-grade honey) to help control bacterial burden and odor. (Strength of Evidence = C)

4.4. Consider use of charcoal or activated charcoal dressings to help control odor. (Strength of Evidence = C)

4.5. Consider use of external odor absorbers for the room, (e.g., activated charcoal, kitty litter, vinegar, vanilla, coffee beans, burning candle, and potpourri). (Strength of Evidence = C)
1. Perform a routine pressure ulcer pain assessment every shift, with dressing changes, and periodically as consistent with the individual’s condition (see Pain Management section). (Strength of Evidence = B)

2. Assess pressure ulcer procedural and non-procedural pain initially, weekly, and with each dressing change. (Strength of Evidence = C)

3. Provide systematic treatment for pressure ulcer pain (see Pain Management section). (Strength of Evidence = C)

4. If consistent with treatment plan, provide opioids and/or non-steroidal antiinflammatory drugs 30 minutes prior to dressing changes or procedures, and afterward. (Strength of Evidence = C)

5. Provide local topical treatment for ulcer pain:
   - Ibuprofen-impregnated dressings may help decrease pressure ulcer pain in adults; however, these are not available in all countries.
   - Lidocaine preparations help decrease pressure ulcer pain.
   - Diamorphine hydrogel is an effective analgesic treatment for open pressure ulcers in the palliative care setting. (Strength of Evidence = B)

6. Select extended-wear-time dressings to reduce pain associated with frequent dressing changes. (Strength of Evidence = C)

7. Encourage individuals to request a time out during a procedure that causes pain. (Strength of Evidence = C)

8. For an individual with pressure ulcer pain, music, relaxation, position changes, meditation, guided imagery, and transcutaneous electrical nerve stimulation (TENS) are sometimes beneficial. (Strength of Evidence = C)

1. Assess psychosocial resources initially and at routine periods thereafter (psychosocial consultation, social work, etc.). (Strength of Evidence = C)

2. Assess environmental resources (e.g., ventilation, electronic air filters, etc.) initially and at routine periods thereafter. (Strength of Evidence = C)

3. Validate that family care providers understand the goals and plan of care. (Strength of Evidence = C)