Palliative Wound Management Workshop

Be the best that you can be!

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Learner Objectives

After attending this program the participant will be better able to:
1. Differentiate between pressure, venous, arterial and diabetic wounds.
2. Discuss palliative wound care goals and realistic expectations of healing.
3. Describe gentle treatment interventions and tips for palliative wound care.
4. Discuss treatment options for multiple patient scenarios.
Classification/Types of Wounds

- Pressure Ulcer - 68%
  - Kennedy Terminal Ulcer
- Lower Extremity
  - Venous, Arterial, Diabetic Neuropathy
- Other
  - Skin Tear
  - Moisture
  - Surgical
  - Malignant

Pressure Ulcer

- Localized tissue destruction caused by unrelieved pressure
- Described in stages
- Treatment goals:
  - Pressure redistribution
  - Balance moisture
  - Manage pain, odor, drainage, infection

STAGE 1

- Localized area of intact skin
- Pressure-related redness
STAGE 2

- Shallow, open area
- Red-pink wound bed
- Intact or open blister

STAGE 3

- Tissue loss involving damage to subcutaneous tissue
- Bone, tendon or muscle is NOT visible
- Granulation tissue may be visualized

STAGE 4

- Full thickness tissue loss
- Exposed bone, tendon, muscle
Unstageable; wound bed is NOT visible

SLOUGH

ESCHAR

Unstageable - Deep Tissue Injury (sDTI)

- Purple or maroon area of discolored intact skin due to damage of underlying soft tissue

- **Assessment:** Examine area adjacent to, or surrounding discolored area for evidence of tissue damage including:
  - Color change
  - Tenderness or pain
  - Bogginess or firmness
  - Warmth or coolness

Kennedy Terminal Ulcer

- A pressure ulcer that may develop during the dying process
- Sudden onset
- Usually pear-shaped, sacral wound
- Irregular borders
- Death may be within 8-24 hours

www.kennedyterminalulcer.com
Lower Extremity Ulcer

- Result of changes in vascular status
- Treatment goals:
  - Balance moisture
  - Facilitate circulation
  - Manage pain, odor, drainage, infection

Venous Insufficiency Ulcer

- Caused by:
  - Loss of valve function
  - Vein obstruction
  - Calf muscle failure
- Treatment includes:
  - Maintain a moist wound bed
  - Leg elevation
  - Compression

Arterial Ulcer

- Caused by narrowing or blockage of arterial blood flow
- Treatment includes:
  - Maintain a DRY wound bed
  - Legs dependent
  - Monitor pulses
Diabetic Neuropathic Ulcer

- Caused by the neuropathic and small blood vessel complications of diabetes
- Typically occur over the bottom surface of the foot
- Treatment includes:
  - Maintain a moist wound bed
  - Pressure redistribution
  - Monitor blood glucose

Other Wounds

- Skin Tears
- Moisture damage
- Surgical
- Malignant tumors

Skin Tears

- Result from shear, friction or trauma to the skin causing separation of skin layers
- Commonly occur on arms and legs
- Treatment goals:
  - Approximation
  - Protection from injury and infection
Moisture Damage

- Skin damage resulting from moisture
  - Wound exudate
  - Urine and stool (Incontinence Dermatitis)
  - Perspiration

- Treatment goals:
  - Identify cause
  - Protect skin with moisture barrier creams and lotions

Malignant Tumors

- "Fungating" describes a painful condition that occurs when malignant cells infiltrate or erode the barrier of the skin
- 62% develop in area of breast, head, neck

- Treatment goals:
  - Management of pain, odor and drainage
  - Comfort measures

Radiation Dermatitis RD

- Radiation dermatitis (RD) may result from radiotherapy
- Often occurs within the first 4 weeks of treatment

- Treatment goals:
  - Donate moisture if dry
  - Absorb moisture if moist
  - Topical steroids to reduce pain, itching
Surgical Wounds
- Surgical intervention may result in healed or non-healing incisions and wounds
- Treatment goals:
  - Management of pain, odor, drainage, prevent infection

REALISTIC WOUND STRATEGY

Healing vs Non-Healing
- Prevention
- Prescription (aggressive, may heal with treatment)
- Preservation (maintenance)
- Palliation (comfort and care)

Determine wound care goals with patient and family. Treatment may progress from cure to comfort as Healing may NOT be realistic.
Palliative Wound Care Goals

- Prevent deterioration
- Reduce discomfort and pain
- Contain *exudate*
- Manage odor
- Prevent infection

Minimize Wound Pain

- Minimize frequency of dressing change
  - Pre-medicate
  - Gently remove dressing
  - Shower or cleanse with warm solution
  - Use non-adherent dressings
  - Reinforce original dressing
- Customize turn schedule
- Provide systemic or topical analgesics
  - Lidocaine
  - Morphine gel

Manage Exudate and Weeping

- Cleanse (*shower if ambulatory*)
- Protect peri-wound skin
- Select absorbent product (*Alginate, foam*)
- Apply dressings in layers
  1. Non-adherent
  2. Highly absorbent
  3. Secure

Wound pouch if appropriate
Control Bleeding

- Minimize dressing changes
  - Non-adherent dressing
- Treatment of bleeding
  - Pressure dressing/Calcium Alginate
  - Apply ice pack
  - Silver Nitrate
  - Monsell’s solution (Styptic)
  - Quick clot gauze
  - Afrin*
  - Epinephrine solution*

* Off-label vasoconstrictor

Managing Wound Odor

- Thoroughly cleanse (shower if ambulatory)
- Treat underlying cause
  - Debride necrotic tissue
  - Monitor incontinence
  - Control infection

Fecal containment device may be helpful in later stages

Antiseptic Cleansing Solutions

Beneficial if NO realistic expectation of healing

- Iodine (Betadine)
- Acetic Acid
- Sodium hypochlorite (Dakin’s Solution)
- Hydrogen Peroxide
- Metronidazole (Flagyl)

These solutions will interfere with healing, however, decrease bacterial burden.
Products to Manage Odor

- Activated charcoal
  - Used to absorb exudate and trap odor
  - Must be sealed and kept dry
- Metronidazole (Flagyl)
- Silver antimicrobial
- Honey

Neutralize odors

- Charcoal
- Kitty litter
- Coffee grounds
- Candle
- Baking soda – sprinkle after dressing is applied

Alternatives

- Vanilla
- Aromatherapy
- Vinegar (cider)
- Beware of perfumes

* Dispose of soiled dressings properly

Managing Infection

- Cleanse
- Debride
- Treat cause of infection
OK, this is simple.....

What does the wound need?
What does the product do?

- If the wound is wet...absorb it
- If the wound is dry...donate moisture
- If the wound is shallow...cover it
- If the wound is deep...fill it

Tools of our trade........

Transparent Film

- Non-absorptive, water proof
- Maintains moist environment, supports debridement

- **Indications:** Minimal exudate, secondary dressing
- **Contraindications:** Infected wounds, dead space
Hydrocolloids
- Light/moderate absorption
- Support autolytic debridement

- **Indications:** Shallow wounds, light/moderate exudate, may be used as a secondary dressing

- **Contraindications:** Infection, heavy drainage, wounds with dead space

Hydrogels
- Donate moisture, support debridement
- Fill dead space, minimize pain

- **Indications:** Red, none/minimal drainage

- **Contraindications:** Heavily draining wounds

Alginates and Foams
- Wick, absorb large amounts of exudate
- Maintain a moist wound bed, support debridement
- Alginates fill dead space

- **Indications:** Heavy drainage, dead space (alginate)

- **Contraindications:** Dry wounds, minimal exudate

*Alginate may be covered with foam for heavy drainage*
Non-adherents
- Primary contact layer
- May remain in wound bed*; change absorbent layer
- Effective in reducing wound trauma

* Confirm with manufacturer’s information

Honey
- Promotes moisture balance
- Prohibits bacterial growth (Antimicrobial)
- Supports debridement
- Eliminates odor
- **Indications:** All wounds
- **Contraindications:** Allergy to pollen or bee venom

Silver Antimicrobial Dressing
- Kills MRSA, VRE, E coli, yeast and fungi
- Available in all dressing categories
- **Indications:** Infected wounds
- **Contraindications:** Concern about bacterial resistance
What stage is this pressure ulcer?
____ Stage 3
____ Stage 4
____ Unstageable

What are the treatment goals?
____ Contain drainage
____ Debridement
____ Manage pain
____ Manage odor
____ Prevent, manage infection

Select a topical treatment:
____ Transparent
____ Hydrocolloid
____ Hydrogel
____ Alginate or foam
____ Other

Necrotic tissue covers this very painful left heel wound. Minimal drainage. No infection.

What stage is this pressure ulcer?
____ Stage 3
____ Stage 4
____ Unstageable

What are the treatment goals?
____ Debridement
____ Contain drainage
____ Manage pain
____ Manage odor
____ Prevent, manage infection

Select a topical treatment:
____ Transparent
____ Hydrocolloid
____ Hydrogel
____ Alginate or foam
____ Other

Heavily-draining coccyx wound with bone and healthy granulation tissue visible. Moisture damage noted to periwound area.

What stage is this pressure ulcer?
____ Stage 3
____ Stage 4
____ Unstageable

What are the treatment goals?
____ Contain drainage
____ Debridement
____ Manage pain
____ Manage odor
____ Prevent, manage infection

Select a topical treatment:
____ Transparent
____ Hydrocolloid
____ Hydrogel
____ Alginate or foam
____ Other

Non-viable yellow, tan tissue right buttock. Necrotic black/brown tissue left buttock. Small amount of drainage. Patient cries in pain with positioning.
What is the etiology of this wound?
- Venous Insufficiency
- Arterial Ischemia
- Diabetic Neuropathy

What are the treatment goals?
- Manage drainage
- Debridement
- Manage pain
- Manage odor
- Prevent, manage infection

Select a treatment:
- Transparent
- Hydrogel
- Hydrocolloid
- Alginate or foam
- Other

| Wet gangrene of forefoot and toes. Drainage and soft tissue swelling due to infection. Painful. |
| How would you describe this wound? |
| What are the treatment goals? |
| Contain drainage |
| Debridement |
| Manage pain |
| Manage odor |
| Prevent, manage infection |
| Select a treatment: |
| Transparent |
| Hydrogel |
| Hydrocolloid |
| Alginate or foam |
| Other |

| Reddened area is a result of bowel and bladder incontinence. |
| How would you describe this wound? |
| What are the treatment goals? |
| Contain drainage |
| Debridement |
| Manage pain |
| Manage odor |
| Prevent, manage infection |
| Prevent social isolation |
| Select a treatment: |
| Transparent |
| Hydrogel |
| Hydrocolloid |
| Alginate or foam |
| Honey |
| Activated Charcoal |
| Metronidazole |

| Malignant wound is painful with heavy drainage and foul odor. |
| How would you describe this wound? |
| What are the treatment goals? |
| Contain drainage |
| Debridement |
| Manage pain |
| Manage odor |
| Prevent, manage infection |
| Prevent social isolation |
| Select a treatment: |
| Transparent |
| Hydrogel |
| Hydrocolloid |
| Alginate or foam |
| Honey |
| Activated Charcoal |
| Metronidazole |
Deep wound with muscle, bone and tendon visible. Very foul odor and heavy drainage.

What stage is this pressure ulcer?
- Stage 3
- Stage 4
- Unstageable

What are the treatment goals?
- Contain drainage
- Debridement
- Manage pain
- Manage odor
- Prevent, manage infection

Select a treatment:
- Transparent
- Hydrogel
- Hydrocolloid
- Alginate or foam
- Other

Sacral/coccyx wound. Subcutaneous fat is visible but bone, tendon or muscle are not exposed. Minimal drainage.

What stage is this pressure ulcer?
- Stage 3
- Stage 4
- Unstageable
- Unstaging

What are the treatment goals?
- Contain drainage
- Debridement
- Manage pain
- Manage odor
- Prevent, manage infection

Select a treatment:
- Transparent
- Hydrogel
- Hydrocolloid
- Alginate or foam
- Other

Pressure damage right ear caused by elastic from an oxygen mask and wearing glasses.

What stage is this pressure ulcer?
- Stage 3
- Stage 4
- Unstageable

What are the treatment goals?
- Contain drainage
- Debridement
- Manage pain
- Manage odor
- Prevent, manage infection

Select a treatment:
- Transparent
- Hydrogel
- Thin Hydrocolloid
- Alginate or foam
- Other
F.R.A.I.L  Palliative Wound Care
Healing Probability Assessment Tool

Communication
Families appreciate:
• Clear information about the patient’s wound and treatment
• Assurance of patient’s comfort

The more items checked on the list, the less likely that the wound(s) will achieve a sustainable, complete closure.

- Wound(s) is over 3 months old, or is a recurrence of a pre-existing breakdown
- Patient spends 20 or more hours of 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 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
- Wound is associated with anemia disease
- Wound is full thickness, with presence of tunneling
- Blood values indicate a low oxygen carrying capacity
- Blood values indicate an exhausted or decreasing immune capacity (i.e., low lymphocyte count)
- Blood values indicate below normal protein levels (low prealbumin, transferrin, and albumin)
References