

## **Palliative Wound Care And Healing Probability Assessment Tool**

### Introduction

The decision to invoke palliative, or non-healing objectives for chronic skin wounds requires consideration of each individual patient's:

- Overall health status including their immune system and nutritional baseline;
- Ability to independently comprehend and participate in health care decisions;
- Wound characteristics, including age of wound(s); and,
- Living arrangements, social/family support system, and access to healthcare resources.

The authors of this palliative healing probability assessment tool envisioned the frail elderly, with increasing levels of immobility, to be the primary beneficiary. Frail institutionalized elderly with diminished decision-making capacity require healthcare professionals to seek family involvement in any decision that foregoes wound healing as its primary goal. Informed families and/or patients can then choose to prioritize comfort and attainment of quality of life objectives as the guiding consideration for selection of wound care treatments. This paradigm of wound care places the patient *first*, adjusting the management of wound(s) to fit the priorities and wishes of the patient. When wound closure is removed as the primary goal of a treatment plan, caregiver focus can then shift to what provides the most comfort while offering the highest level of independence and dignity possible. Aspiring to comfort and wound stability as opposed to wound healing could be the first deliberate and tangible recognition that a patient will never return to his/hers baseline of independence. Therefore it is imperative that caregivers provide clear and unequivocal explanations regarding available options of management.

In determining a care plan for palliative management of wound(s), caregivers must establish a threshold of options, ensuring that choices will provide protection against generally avoidable complications, such as infection, abscesses, and pain. However, caregivers must deftly shift their focus from the wound to the whole patient, and be willing to relinquish what may be best for the wound, to what is best for the patient. It is important that caregivers try to balance the patient's desires against avoiding complications. If a patient/family elect options that are likely to result in some kind of deterioration of the wound, but clearly understand that in making their decision, then wound care should be adjusting accordingly.

### The Palliative Decision

On admission to a long term care facility or home care agency it is imperative that goals are established from the patient's perspective. Unless patients and family are told otherwise, they generally assume that all wounds can and should heal. Although they may be discouraged by the longevity or repeated occurrences of breakdown, they are likely to believe that it is simply a matter of finding the right caregiver to achieve healing. A comprehensive assessment of factors known to impact healing will form the basis for guiding discussions with the patient and family regarding wound care. Palliative treatment of wounds has as its primary goal to give patients back control of their lives. Non-healing goals may better accommodate objectives that facilitate the highest level of independence and dignity possible.

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 that the wound(s) will achieve a sustainable complete closure.

### Healing Probability Assessment Tool

- Wound(s) is over 3 months old, or is a reoccurrence 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 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
- Blood values indicate an exhausted or decreasing immune capacity (i.e., low lymphocyte count)
- Blood values indicate below normal visceral protein levels that have not responded to nutritional support efforts (i.e., low prealbumin, transferrin, retinol-binding protein, and albumin)

### The Palliative Treatment Plan

After estimating the probability for wound closure, the next step is establishing realistic patient sensitive wound care objectives. The plan begins with determination of the patient/family's goals for independence, comfort, and activity level. These goals are then weighed against the patient/family's tolerance for the limitations that wound healing would impose on those goals. A palliative wound plan does *not* have healing as its primary foci. Removing healing as the primary consideration in designing a care plan creates opportunities to achieve a patient's more global objectives. Suddenly, a wound that has consistently failed to respond to treatment is no longer a source of patient and family frustration. Control has been returned to the patient. The patient instead *can* measure achievement of their non-healing objectives.

The probability for healing will be informed by the "score" or number of factors checked on the above tool. Using the findings of the tool, caregivers can realistically establish not only the required treatments to move toward a healing goal, but more importantly, estimate the likelihood of success. For example, a patient and family that prioritizes total healing, and is judged to have a high probability for healing, may enter an aggressive care plan and achieve that goal. But, if on the other hand, that same patient has several elements checked on the probability assessment tool, indicating poor healing potential, adjustment of the patient's expectations may be in order. The rigors of a care plan that targets healing in a compromised patient must be outlined within the context of reduced probability for healing. Many patients and families may be hearing this outcome scenario for the first time, and will therefore need support in order to understand the limitations identified. Once accomplished, the patient and family are ready to move on to the next stage – palliative wound management.

Palliative treatment approaches for wounds will include much the same techniques and local care already familiar to wound care providers. The primary distinction will not be the tools used, rather, it will be how they are used. For example, a palliative plan could translate to minimal local care designed to avoid frequent repositioning and wound manipulation. This treatment choice is made understanding that the plan may only protect the wound site from infection, without creating the optimal environment for healing to occur. Palliative wound care will always start with patient goals, fitting local treatment to those limitations, rather than wound care dictating limitation onto patients.

The frail elderly patient admitted to a long-term care facility without skin breakdown is routinely assessed for level of risk for pressure ulcers. Patients whose score indicate an increased likelihood for breakdown should immediately begin the process of determining the appropriateness for palliative management approaches, if an ulcer develops. Patients and families should be informed of the findings of increased risk for skin breakdown along with an explanation of the specific factors judged to be driving that risk. The factors that cannot be reversed or are likely to become more pronounced, like a diminishing level of mobility, should be thoroughly discussed with the patient and family to establish realistic expectations. By anticipating and explaining the very real

probability of skin breakdown, clinicians remove much of the stigma of negligence associated with skin breakdown and potentially avoid disillusionment on the part of the patient and family. Instead patients and their families are ready to transition into a palliative plan of care that considers the patient's personal goals for maximizing the quality of their remaining life.

Palliative, or non-healing goals expand options for patients, releasing them from rigors such as daily whirlpools, bedside debridement, nocturnal dressing changes, and more. But non-healing objectives must be discussed within the context of each patient's considering those factors that create impediments to healing. No patient or family should perceive that a palliative choice for wound care means giving up, rather, they should understand that they are maximizing the options available that help patient's achieve comfort, independence, and choice.