

Palliative Wound Care and Documentation

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I have no disclosures

Palliative Wound Care and Documentation

Objectives

1. Describe factors that impact wound healing
2. Identify a wound prognosis
3. Construct appropriate wound documentation

Patient has a wound

Partial
Thickness

Full
Thickness

Replace with like
tissue (damage to
epidermis and dermis)

Replace with connective
tissue (damage through
epidermis, dermis into
subcutaneous fat)

Examples: stage
1 & 2 pressure
injuries, MASD,
skin tears

Examples: stage 3
& 4 pressure
injuries, arterial &
venous ulcers

Chronic Wounds

- ▶ Chronic wounds
 - ▶ Still present after 4 weeks
 - ▶ Full thickness
 - ▶ Do not complete phases of wound healing in the normal timeframe.

- ▶ In 2017, cost of chronic wounds for Medicare beneficiaries ranged from \$28.1-31.7 billion.



Nussbaum S.R., et al. (2018). An economic evaluation of the impact, cost and Medicare policy implications of chronic nonhealing wounds. *International Society for Pharmacoeconomics and Outcomes Research's Value in Health Journal*, 21(1):27-32.

Sen, C.K. (2019). Human wounds and its burden: an updated compendium of estimates. *Advances in Wound Care*, 10(5):39-48.

Chronic Wounds and Older Adults

- ▶ Disproportionately affect older adults
 - ▶ Due to:
 - ▶ Rapid expansion of adults 65 and older
 - ▶ Increase in diabetes and obesity worldwide
 - ▶ More older adults undergoing surgery = risk of wound complications
- ▶ Impose significant morbidity and mortality
- ▶ Individuals 85 and older have the highest incidence of chronic wounds

Intrinsic Factors

- ▶ Age

- ▶ Co-morbid Conditions

- ▶ PVD/PAD
- ▶ Diabetes
- ▶ COPD
- ▶ Heart Failure
- ▶ Progressive neurological disorders
- ▶ Obesity
- ▶ Proinflammatory conditions
- ▶ H/O CABG
- ▶ Previous pressure injury

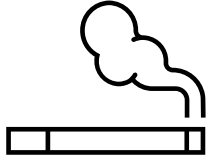
- ▶ Nutrition and hydration status

- ▶ 2019 ASPEN guidelines emphasize importance of validated nutrition tools

- ▶ Medications

- ▶ Steroids
- ▶ NSAIDs
- ▶ Anticoagulants/antiplatelets
- ▶ Diuretics
- ▶ Immunosuppressants
- ▶ Antibiotics

Extrinsic/Other Factors



- ▶ Smoking & Alcoholism
- ▶ Caregiver involvement - capability to do dressing changes?
Turning/repositioning?
- ▶ Hospital Length of Stay
- ▶ Head of bed positioning
- ▶ Medical Devices and Equipment
- ▶ Access to resources
- ▶ Adherence/Compliance to Treatment plan.

Flemister, B. (2016). Skin and wound care for the geriatric population. In D.B. Doughty & L.L. McNicol, *Core Curriculum: Wound Management* (pp.220-241). Wound, Ostomy, & Continence Nurses Society

Gould, L., et al. (2015). Chronic Wound Repair and Healing in Older Adults: Current Status and Future Research. *Journal of the American Geriatrics Society*, 63(3), 427-438.

Gould, L. (2016). Wound Healing in Older Adults. *Rhode Island Medical Journal*, accessed on 8/6/2021 from [2016-02-34-wound-gould.pdf \(rimed.org\)](https://www.rimed.org/2016-02-34-wound-gould.pdf)

Alam, W., Hasson, J., & Reed, M. (2021). Clinical Approach to Chronic Wound Management in Older Adults. *Journal of the American Geriatrics Society*, 1-8.



Epiboly



Callous



Maceration

Impaired Wound Edges

Palliative Performance Scale

- ▶ Measures 5 domains: ambulation, activity level and evidence of disease, self-care, oral intake, and level of consciousness
- ▶ 2018 Systematic Review by Baik & Colleagues
 - ▶ All care settings - palliative units, SNFs, home hospice
 - ▶ Patients with varying diagnoses
 - ▶ Concluded that PPS was a significant predictor of survival for patients with cancer and end-of-life diagnoses

| Palliative Performance Scale (PPSv2) version 2 ² | | | | | | |
|---|-------------------|---|-------------------------------------|-------------------|---------------------------------|--|
| PPS Level | Ambulation | Activity & Evidence of Disease | Self-Care | Intake | Conscious Level | |
| 100% | Full | Normal activity & work No evidence of disease | Full | Normal | Full | |
| 90% | Full | Normal activity & work Some evidence of disease | Full | Normal | Full | |
| 80% | Full | Normal activity with effort Some evidence of disease | Full | Normal or reduced | Full | |
| 70% | Reduced | Unable to do normal job/work Significant disease | Full | Normal or reduced | Full | |
| 60% | Reduced | Unable to do hobby/housework Significant disease | Occasional assistance necessary | Normal or reduced | Full or confusion | |
| 50% | Mainly sit/lie | Unable to do any work Extensive disease | Considerable assistance required | Normal or reduced | Full or confusion | |
| 40% | Mainly in bed | Unable to do most activity Extensive disease | Mainly assistance | Normal or reduced | Full or drowsy +/- confusion | |
| 30% | Totally bed bound | Unable to do any activity Extensive disease | Total care | Normal or reduced | Full or drowsy +/- confusion | |
| 20% | Totally bed bound | Unable to do any activity Extensive disease | Total care | Minimal to sips | Full or drowsy +/- confusion | |
| 10% | Totally bed bound | Unable to do any activity Extensive disease | Total care | Mouth care only | Drowsy or coma +/- confusion | |
| 0% | Death | - | - | - | - | |

Stable

Hospice Appropriate

Co-morbidities

Goals of Care

Mobility

Nutritional Status

Open Wound

Wound Prognosis

Medications

Usual wound facts
(appearance, location,
drainage, etc.)

Who's providing
the care?

Financial status

Wound Prognosis

Healable

- Can heal with proper wound management and underlying causes addressed
- Stable intrinsic factors
- Adequate blood supply

Maintenance (healing potential but...)

- Patient/health system barriers compromising healing like uncontrolled diabetes, patient nonadherence, smoking, etc. causing delayed wound healing

Nonhealable (palliative wounds)

- Cannot heal due to irreversible causes/illnesses
- Critical ischemia; not treatable due to malignancy; negative protein balance

Healing Probability Assessment 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

http://www.manukahonning.no/uploads/3/9/6/3/39639435/_palliative_wound_care_and_healing_probability_assessment_tool.pdf

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.

Palliative 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
- ▶ Rather than a primary focus on “healing” the wound, the treatment goals for the patient are to provide comfort and manage the symptoms associated with the wound. Examples include pain, odor, wound exudate, and risk of infection.
- ▶ “Even with limitations on wound healing, it is inappropriate to ignore wounds or declare them untreatable in individuals at end of life.” - Dr. Tippett

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>

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.

Kennedy Terminal Ulcer (KTU)

Concept presented by Karen Lou Kennedy, NP

Residents that developed an ulcer = 55.7% died within 6 weeks

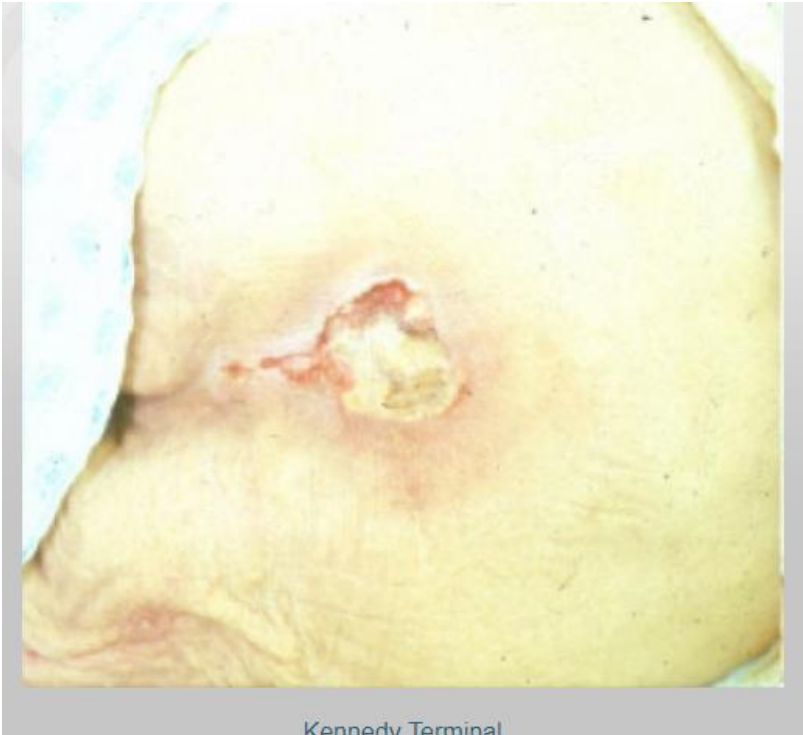
Sudden appearance of a red, yellow, or black bilateral pear-shaped ulcer most commonly on the sacrum or coccyx

2019 Scoping Review by Latimer and colleagues

Limited KTU evidence

No consistent agreement of etiology

KTUs are unavoidable



Permission for photo use granted by Karen Lou Kennedy, NP
<http://www.kennedyterminalulcer.com/>

Trombley-Brennan Terminal Tissue Injury

- ▶ First descriptive study published in 2012 - skin changes different in appearance from deep tissue injuries and Kennedy ulcers
 - ▶ 80 patients with unique skin changes - 75% died within 72 hours
- ▶ Additional retrospective study published in 2019
 - ▶ 86 additional charts reviewed - median death within 30 hours
 - ▶ Wounds exhibited linear pattern, butterfly pattern, or had a white center
 - ▶ Tissue changes did not involve a break in the skin's integrity

Ayello, et al. (2019). Reexamining the Literature on Terminal Ulcers, SCALE, Skin Failure, and Unavoidable Pressure Injuries. *Advances in Skin & Wound Care*, 32(3), 109-121.

Brennan, M., Thomas, L., & Kline, M. (2019). Prelude to Death or Practice Failure? Trombley-Brennan Terminal Tissue Injury Update. *American Journal of Hospice & Palliative Medicine*, 36(11), 1016-1019.

Trombley, K., Brennan, M. R., Thomas, L., & Kline, M. (2012). Prelude to Death or Practice Failure? Trombley-Brennan Terminal Tissue Injuries. *American Journal of Hospice and Palliative Medicine*, 29(7), 541-545.

Skin Failure

S.C.A.L.E

- ▶ Does the skin fail like any other organ?
- ▶ S.C.A.L.E. - Skin Changes at Life's End - Consensus statement published in 2009
 - ▶ Multi-day panel discussion with input from 69 noted wound care experts in a modified Delphi method approach
 - ▶ Created 10 statements - link to article:
<https://www.epuap.org/wp-content/uploads/2012/07/SCALE-Final-Version-2009.pdf>

Panel concluded, “*Our current comprehension of skin changes that can occur at life’s end is limited; that SCALE process is insidious and difficult to prospectively determine; additional research and expert consensus is necessary.; and contrary to popular myth, not all pressure ulcers are avoidable.*”

COVID Skin Manifestations

“Evidence-based standards of pressure injury prevention have not changed. However, we reasonably anticipate that unavoidable pressure injury rates may increase during the COVID-19 crisis.”



Unavoidable Pressure Injury during COVID-19 Pandemic:

A Position Paper from the National Pressure Injury Advisory Panel



Skin Manifestations with COVID-19: The Purple Skin and Toes that you are seeing may not be

Deep Tissue Pressure Injury.

An NPIAP White Paper

Skin discoloration or injury on non-loaded locations are likely not pressure injuries.

Differential Identification Guide

DTI, KTU/Skin Failure, or COVID Associate Skin Damage?



Deep Tissue Injury

- Deep: bone/muscle interface
- Pressure injury
- Usually avoidable



Kennedy Terminal Ulcer/Skin Failure

- Superficial to Deep
- Multi-organ failure
- Unavoidable



COVID Skin Damage

- Superficial
- Coagulopathy
- Unavoidable

 COVID Skin Campaign | PALTC

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Attribution to NPIAP and Dot Weir, RN, CWON, CWS

NPIAP Comments on COVID-19 and Pressure Injuries

- ▶ Avoidable vs. unavoidable is case-by-case, including intrinsic issues in the critically ill patient and extrinsic issues in the health care facility.
- ▶ COVID-19 skin manifestations may mimic pressure injuries and should be considered in the differential diagnosis
 - ▶ Microvascular occlusions + pressure + shear/stress = non-modifiable risk unable to overcome even with reasonable pressure injury prevention
- ▶ Will Post-acute Sequelae of COVID-19 (PASC), i.e., “Long haulers” impact wound healing?

Genoseve, G. et al. (2021). Skin Manifestations Associated with COVID-19: Current Knowledge and Future Perspectives. *Dermatology*, 237:1-12.

Proal & VanElzakker. (2021). Long COVID or Post-acute Sequelae of COVID-19 (PASC): An Overview of Biological Factors that May Contribute to Persistent Symptoms. *Frontiers in Microbiology*, 12:698169.



COVID Skin Campaign | PALTC

OUR MISSION

The purpose of the COVID Skin PALTC is to contribute to the awareness and recognition of COVID-19 dermatological manifestations related both to the disease and vaccine in the post-acute and long-term care communities.

Through understanding the incidence and types of dermatological symptoms, our goal is to advance care by enabling accurate identification and reporting.

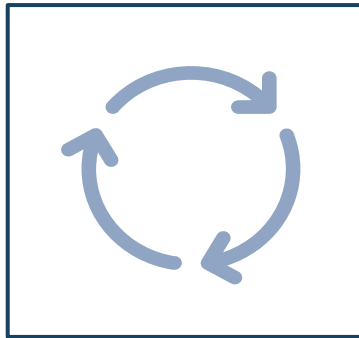
The scope of education includes diagnosis, treatment, documentation and coding.

- Registry address: <http://covidskincampaign.org/>
- Unique about this registry
 - Includes the LTC/Skilled nursing care setting
 - Gathers images
 - Asks for both skin and mucous membrane manifestations
 - Identify when the manifestations take place: before, during and after COVID-19
 - Asks about dermatologic disruptions after vaccination

General Principles of Palliative Wound Care



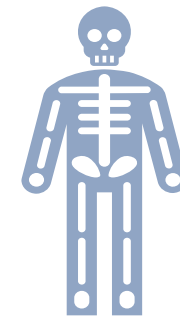
Moist wound environment
(except ischemic)



Manage
bioburden



Care for wound
edges



Prevention
Protection
Off-loading

Palliative Wound Goals of Care

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

Woo. 2017

- 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. 2009

Documentation - Tips

- ▶ Document your wound prognosis and the evidence to support this prognosis
- ▶ Do not be afraid to state the wound might not heal
- ▶ “Delayed wound healing expected due to...”
- ▶ Ischemic wounds: “nonhealable due to no blood flow or expected to further decline due to...”

Documentation - Tips

- ▶ Document what you ARE going to do --- consider using one of the palliative care frameworks
 - ▶ Example: Delayed wound healing expected due to poor nutritional intake, immobility, and PPS 30%. Confirmed with family goals are palliative and focus will be pain management. [plan for pain management here]
 - ▶ Example: Fungating tumor that is unlikely to heal. Patient most concerned with odor. [Plan for odor management here]. Goal is for family to be able to tolerate being at bedside for >30 minutes because malodor will be reduced.”

Patient/Family/Caregiver Wound Education

- ▶ Serious illness conversations/goals of care conversations SPECIFIC to the wound --- document those conversations with families
- ▶ Educate patients and caregivers WHY wound healing is delayed - document this discussion
- ▶ Adjust plans of care for wounds in collaboration with the patient/family/caregiver - ensure alignment with the goals of care and the patient-centered concerns
- ▶ Communicate wound expectations to the team - both internal and external - make sure they understand & helps with consistent messaging to family

Case Study 1: John Doe

- ▶ 67 y/o male (he/him) with metastatic melanoma
- ▶ Comorbidities: COPD, HTN, PVD, osteoporosis, arthritis, not oxygen dependent, and has metastases to bone, skin, and lungs
- ▶ Medications: Dexamethasone, MS Contin, Lisinopril
- ▶ PPS: 30%
- ▶ Eats about 50-75% of the meal served to him from AL staff
- ▶ Lives in assisted living where his wife comes by everyday

John Doe's Wound: Head Tumor

- ▶ Currently using Hydrofiber and ABD pads and wrapping the head
- ▶ This is not managing drainage and/or odor and having difficulties getting the dressing to stay in place, it keeps falling off.
- ▶ Upon Assessment what can we do?

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Goals for Wound Management: Odor and Drainage Management

▶ Odor:

- ▶ ¼ strength Hypochlorite to wound bed for approx. 3-5mins to gently clean wound bed.
- ▶ Crushed Metronidazole 250mg applied to wound bed at time of dressing change.

▶ Drainage (Exudate):

- ▶ Calcium Alginate cut to fit placed onto wound bed, with non-bordered transfer foam or hydroconductive dressing
- ▶ Secured with a Sacral Border foam, in place of wrapping patient up

▶ Securing onto body:

- ▶ Hair was trimmed
- ▶ Able to change QOD to a MWF

Documentation

- ▶ Mr. Doe has a malignant fungating tumor, which is unlikely to heal due to etiology and contributing malnutrition.
- ▶ Goals of care are focused on the most distressing symptoms - odor and exudate management.
- ▶ Currently using hydrofiber and ABD, which is not managing symptoms well.
- ▶ Trial: ¼ Hypochlorite impregnated gauze to wound bed 3-5min, remove and pat dry, sprinkle crushed metronidazole 250mg to wound bed, and cover with calcium alginate and non-bordered foam and secure with border foam.
- ▶ Change QOD and PRN >75% strikethrough.
- ▶ Wound prognosis discussed with patient and wife. They state understanding and agree with symptom management goals of care.

Malignant Fungating Wounds (MFWs)

- ▶ Usually occur 6-12 months before death among patients with advanced or metastatic cancer
- ▶ Anticipate to see more due to people living longer with cancer
- ▶ Associated with physical and psychosocial symptoms
- ▶ PALCARE framework for comprehensive, patient-centered approach
 - ▶ Prognosis
 - ▶ Advance care planning
 - ▶ Living situation (caregiver availability, ability, participation)
 - ▶ Comprehensive history (medical, psychiatric, social, spiritual)
 - ▶ Assessment of the wound
 - ▶ Recommendations for symptoms management
 - ▶ Education to patient, family, and involved staff

Tilley, et al. (2020). Symptoms of Malignant Fungating Wounds and Functional Performance among Patients with Advanced Cancer: An Integrative Review from 2000 to 2019. *Journal of Palliative Medicine*, 23(6), 848-862.

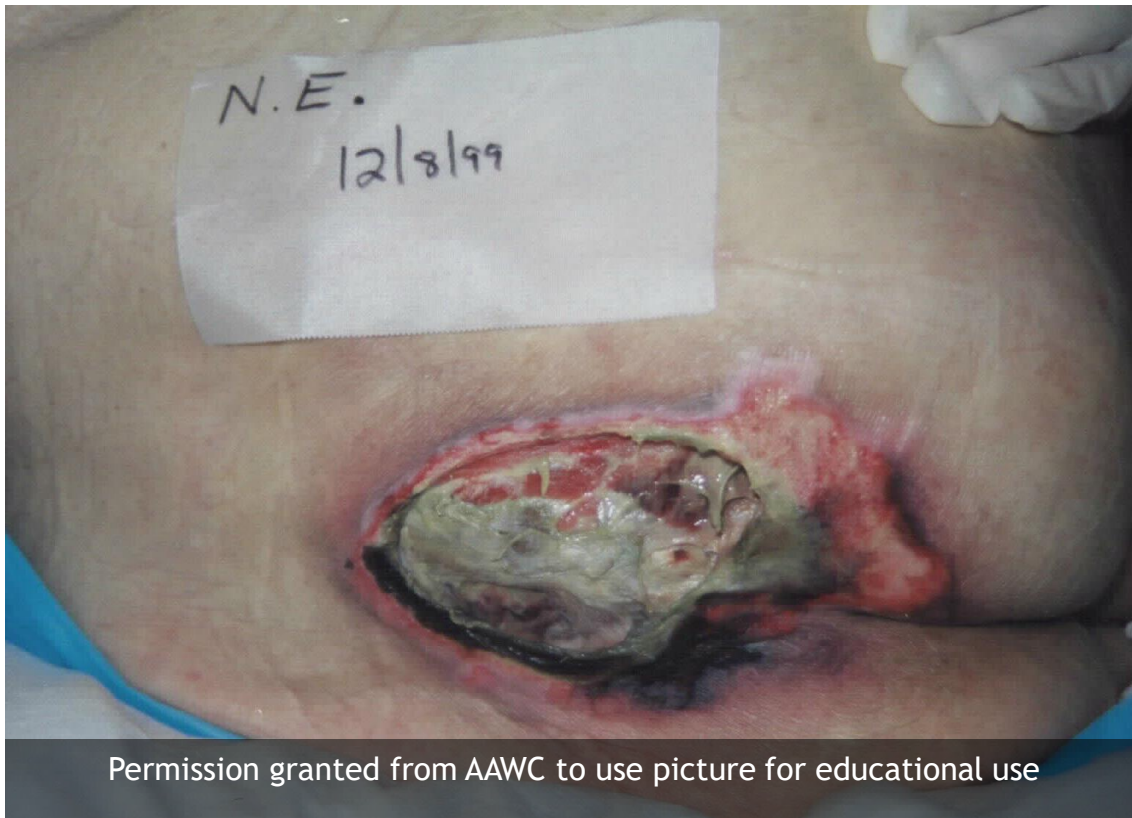
Grocott, P., Gethin, G., & Probst, S. (2013). Malignant Wound Management in Advanced Illness: New Insights. *Current Opinion in Supportive and Palliative Care*, 7(1), 101-105.

Cornish, L. (2019). Holistic management of malignant wounds in palliative patients. *British Journal of Community Nursing*, 24(Sup9), S19-S23.

- ▶ 92 y/o female (she/her) with advanced Alzheimer's Disease
- ▶ Comorbidities: Arthritis, osteoporosis, h/o breast cancer s/p chemotherapy in 1990s, HTN, atrial fibrillation, recent hospitalization for aspiration pneumonia
- ▶ Total care, puree diet, which she does not like - only takes health shakes but taking less and less since return from hospital
- ▶ Medications: Tylenol, lisinopril, metoprolol, warfarin, amoxicillin/clavulanate for 3 more days
- ▶ Lives in Nursing Home, daughter is healthcare agent and lives out of state

Case 2: Jane Doe

Case 2: Jane Doe



- ▶ Has been referred to hospice
- ▶ Returned from hospital with orders for collagenase ointment to wound bed and cover with moist gauze and ABD daily.
- ▶ Asked to see if there is anything “better” for patient’s comfort due to frequent moaning with daily dressing change.

Phone call with Daughter

- ▶ Review any concerning or pressing issues daughter may have
- ▶ Ask to discuss the wound and perceptions of the wound - granted
- ▶ Review with the daughter her mother's declining condition, the poor wound prognosis, discuss possible foley catheter placement
- ▶ Daughter's wishes and goals for her mother
- ▶ Pass along nursing report that since hospital return, PO intake has been minimal to none, and noted Cheyne-Stokes respirations today
- ▶ Review current medications and possibly discontinuing anticoagulant and antiplatelet given dying status

Documentation

- ▶ Unstageable pressure injury to sacrum - unlikely to heal due to poor PO intake, advanced Alzheimer's, and patient showing signs of active dying progress. Spoke with daughter, who agreed to discontinue anticoagulant and antibiotic. Concerned foley would be uncomfortable for patient and declined. Goals for Ms. Doe are comfort and minimizing pain. For wound: cleanse with warm tap water, apply barrier cream over area, lay ABD dressing over the wound, and secure with brief. Change with each incontinence care



Case 3: Mrs. Dear

- ▶ 80 y/o female (she/her) with Parkinson's Disease (PD)
- ▶ Comorbidities: PD related dementia, unsteady gait, HTN, diet-controlled diabetes, Rheumatoid arthritis
- ▶ Medications: Carbidopa/Levodopa, Lisinopril, prednisone, Tylenol
- ▶ PPS: 40-50%
- ▶ Lives in assisted living

Case 3: Mrs. Dear

- ▶ Fell and sustained multiple skin tears - some to left upper forearm and one on left wrist.
- ▶ Skin tears all have flaps that looked ecchymotic, and wound beds pink to red. Mild to moderate serosanguinous drainage
- ▶ Nurse asks what to do - what dressing, should he cut the flap, how often to change the dressing?

Case 3: Mrs. Dear

- ▶ These wounds can heal - delayed wound healing expected due to age, medications, and comorbid conditions
- ▶ International Skin Tear Advisory Panel Skin Tear Classification
 - ▶ Type 1: No skin loss
 - ▶ Type 2: partial flap loss
 - ▶ Type 3: total flap loss
- ▶ Free tool kit: www.skintears.org/education/tools/skin-tear-tool-kit/

Documentation

- ▶ Multiply Type 2 skin tears to LUE. Delayed wound healing may occur d/t comorbid condition of dementia and medications that impede wound healing. Benefit of continuing medications outweigh discontinuation. Cleanse with saline, gently roll back flap over wed bed as best possible, skin prep to periwound, apply non-adherent dressing, and change 1-2 times per week or if drainage increases, if there is pain, swelling, or other signs of infection.



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