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Focus on wound care in the community

Community hospitals • Dementia and wound care • Palliative wound care

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The Wound Care Alliance UK would like to thank all its members for their support. Please remember, members' feedback is always appreciated. Finally, a very big thank you to all Wound Care Alliance UK trustees for all their hard work, passion and commitment, which is always evident.

The future of wound care is in the community

What a busy year it has been for wound care in the UK, with the European Wound Management Association (EWMA) conference in London this year showing just how far UK nurses and clinicians have come in making tissue viability a specialty that demands attention. It has also been an exciting year for the Wound Care Alliance UK, with our own annual conference continuing where it left-off last year, with an event that highlighted all the good work being done by wound care clinicians right across the UK.

Wound care is changing as the population changes — increasing amounts of older people, more patients with long-term conditions and government initiatives aimed at getting people out of hospital mean that more wound care than ever will be taking place in the community. To reflect this, and keep up to date with current trends in practice, this supplement takes a look at some of the essentials of community wound care. First of all, Jackie Griffin investigates the community hospital and how it is increasingly becoming a resource for wound care patients; Rosie Callaghan and Jola Merrick examine the relationship between dementia and wound care; and finally, I look at best practice in palliative wound care and how this will increasingly become part of the community nurse's role in the future.

The Wound Care Alliance UK want you to have the best tools possible to do the best job you can for patients, and we hope that this supplement will help you through one of the biggest transitions ever seen in UK healthcare — the move from secondary to primary care.

Jackie Stephen-Haynes, *chair of the Wound Care Alliance UK*

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IN BRIEF

- Community hospitals now offer a range of clinically, cost effective treatments across the whole wound-healing spectrum.
- This allows for more complex patients to be discharged from the acute district general hospitals and to continue with their treatment, while at the same time freeing up costly acute beds.
- Community hospitals could be considered the most appropriate place for rehabilitation and planning of forward care.
- This article reviews the role of community hospitals and their strategic function in providing high-quality effective wound care within an integrated healthcare system.

KEYWORDS:

- Community hospital
- Wound care
- Effective treatment
- Integrated systems
- Complex patients

Wound care in the community hospital

Jackie Griffin

Historically, community hospitals have their origins in cottage hospitals — these were often built and paid for by local communities with the services offered reflecting the needs of the local population. Now, however they play an important role in the wider NHS, offering services that complement those of neighbouring district general hospitals.

Community hospitals also provide an extension to primary care services and act as a source of referral to and from acute hospitals, as well as for the 'step-down' services needed by many patients following acute episodes of ill health (Department of Health [DH], 2000).

Recently, there has been a significant rise in the number of purpose-built community hospitals and treatment centres, demonstrating that they are no longer simply regarded as rural backwaters, but are also appropriate for densely populated urban areas with degraded housing stock and poor family networks (DH, 2000).

However, staff in community hospitals need to inform the public of the increasingly complex cases that they can manage, which can offer benefits to patients and relatives alike. Services offered now include:

- Outpatients' clinics
- Operating theatres
- Endoscopy sessions
- Maternity
- Elderly mental health
- Physiotherapy
- Occupational therapy.

It should increasingly be considered inappropriate for patients to be admitted to the acute sector for procedures that are offered by a local community hospital.

Are you sure that you are carrying out holistic wound care assessments? This should include, the wound itself; the patient's perception and impressions of the wound; as well as any comorbidities that might adversely affect the wound, such as diabetes.

WOUND CARE

The cost to the NHS of treating wounds has been estimated as between £2.5–3.1 million (Posnett et al, 2009), with up to 27–50% of hospital beds in the acute sector

WHAT IS THE 'PRODUCTIVE' COMMUNITY HOSPITAL?

This programme supports frontline staff working in a community hospital setting to improve the effectiveness, safety and reliability of care they provide to patients. Using learning modules with specific improvement techniques and measures, staff are able to follow a process which leads to improvement in the three clinical areas of focus: inpatients, day hospitals and minor injuries units.

Find out more about the 'productive community hospitals programme' at: www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html

Jackie Griffin, tissue viability clinical nurse specialist, Montgomery County Infirmary, Powys, Wales

Figure 1. *Different elements that must be considered when attempting to heal a wound.*

being taken up by patients requiring some form of wound management. Therefore, it makes financial sense for community practitioners to treat patients who require complex wound care in community hospitals rather than more expensive acute settings.

By managing these patients effectively, clinicians in community hospitals have the chance to be at the forefront of proactive nursing care. Similarly, by adopting newer wound-healing strategies, they can reduce costs and improve patient experience.

What is the role of the wound care formulary?

A wound care formulary is a list of products and treatment options that have been endorsed by the local trust or health board to assist practitioners in choosing products for their patients' wounds. For clinicians to provide the best healing environment, they need different products at different stages of the wound-healing trajectory.

However, dressings are only part of the jigsaw of strategies that are available to promote wound healing (*Figure 1*), and the choice of wound care product must follow comprehensive holistic wound assessment that involves examining the patients themselves as well as their wounds (see below) (Ousey and Cook, 2011). Where practitioners are unsure of best treatment, referral to a specialist tissue viability nurse should be made.

Wound assessment

Wound assessment must review all aspects of the wound (Ousey and Cook, 2012), whether it is a linear surgical wound, a dehisced open cavity, leg ulcer or pressure ulcer.

Debridement

Tissue type present should be identified and any devitalised tissue removed. Debridement is essential to move the wound along the healing continuum (Young, 2014). Within a community hospital setting, this can be undertaken in a number of ways:

- Using wound dressings that support autolysis (the removal of devitalised tissue by the body's own enzymes)
- Mechanically using a monofilament soft pad (i.e. Debrisoft®; Activa Healthcare).
- Using larval therapy.

Sharp debridement is another technique for removing necrotic material, but this should only be undertaken by trained clinicians.

Infection

Before a wound can successfully be healed, any infection must be identified. Cutting and White (2005) list the signs and symptoms to assist nurses in this (*Tables 1* and *2*).

Wound infection can be treated by using topical antimicrobial dressings (according to the local formulary as suggested above). However, if the patient is systemically unwell with pyrexia (fever) and tachycardia (heart rate that exceeds the normal resting rate), oral antibiotics can be prescribed.

Exudate

Although exudate is one of the body's natural responses to a wound, being produced during the inflammation phase and creating a moist environment for autolytic debridement (Griffin, 2014), in chronic wounds the high level of matrix metalloproteinases (MMPs) in the wound fluid can cause tissue breakdown in the periwound area. Vowden and Vowden (2003) explain that poorly managed exudate can increase the risk of infection and lead to the potential 'knock-on' effect of delayed wound healing.

Managing excess wound exudate with an alginate/fibre-type dressing will protect the periwound skin and help to prevent any breakdown of this tissue. Conversely, epithelial migration can be slowed and healing delayed if a wound is too dry, illustrating the importance of balance in providing a moist wound-healing environment.

Table 1:	Signs and symptoms of infection: primary intention
	Cellulitus
	Discharge
	Delayed Healing
	Discolouration
	Unexpected pain/ tenderness
	Bridging of epithelium or soft tissue
	Malodour
	Wound breakdown

Practice point

Wound assessment must review all aspects of the wound, including whether it is a linear surgical wound, a dehisced open cavity, leg ulcer or pressure ulcer.

The patient's role in wound assessment

The role of patients in wound assessment is important — no one will understand a wound better than the patient themselves and in many cases patients can provide an in-depth history.

Table 2:	Signs and symptoms of infection: secondary intention
	Abscess
	Heat
	Swelling/ oedema
	Redness/erythema
	Cellulitus
	Inflammation
	Discharge
	Delayed healing
	Friable tissue (easily bleeds)
	Pain
	Bridging of epithelium or soft tissue
	Pocketing at the base of the wound
	Malodour
	Increase in wound size

Red Flag **Infection**

Wound infection results from the inability of the patient's body to control the burden of bacteria within a wound. Identifying those factors which increase the likelihood of infection and maximising the patient's natural defences are essential steps in preventing infection. If infection occurs, it is important that clinicians are able to identify the signs and symptoms and initiate speedy and appropriate treatment. Judicious use of topical antimicrobial wound dressings has proven to be an effective method of reducing bioburden, and enables clinicians to reserve the use of antibiotics for those patients in greatest need.

Each patient's wound is affected by physical and psychological elements, as well as social factors. Previously diagnosed health issues such as diabetes are known to mask problems such as wound infection. The patient must be supported to maintain their diabetes at the optimum level to gain the positive effects of wound healing (European Wound Management Association [EWMA], 2008).

The negative effects of smoking on general health have been well-documented in the past (Silverstein, 1992), specifically in wound healing.

Practice point

Wounds need nourishment to heal and older patients may have difficulty maintaining the adequate dietary intake required. Early identification of patients at risk of poor nutrition and referral to dietitians is important. While it is important that patients' nutritional needs are assessed while they are still in hospital, it also necessary to consider how sufficient nutrition will be provided on discharge.

Nicotine is a vasoconstrictor that reduces the nutritional blood flow to the wound and surrounding tissues, resulting in ischaemia and impaired healing. Patients who smoke can be offered alternatives to nicotine and referral to smoking cessation specialists while in hospital.

Wounds need nourishment to heal and older patients may have difficulty maintaining the adequate dietary intake required. Timms (2011) advised early identification of patients at risk of poor nutrition and referral to dietitians. While it is important that patients' nutritional needs are assessed while they are still in hospital, it is also necessary to consider how sufficient nutrition will be provided on discharge.

In some cases, patients may inflict their own wounds. Known as factitious wounds, these injuries can be unusual in presentation and fail to heal whatever treatment is used. Self-harming is a behaviour not an illness, and the cause of the patient's distress will need to be investigated by the mental health team. Self-harm is a problem that is being increasingly recognised in ex-military personnel and unfortunately the UK has the highest numbers of people across Europe that self-harm (Royal College Psychiatrists, 2010).

To a degree, a 'non compliant' older person with a long-term leg ulcer might be considered to be self-harming if they continued to sabotage treatment to retain a level of communication with healthcare staff, for instance.

Careful monitoring of the patient's environment may indicate how the wound was inflicted. Various techniques can be used to either create a wound or ensure that it remains open. In the author's clinical experience, these can include washing wounds in bleach (this presents as highly excoriated and painful periwound skin) and even setting fire to the bandages/dressings. Scissors, razor blades, pens and cigarettes have also been used as ways of maintaining a wound (Corser and Ebanks, 2004).

As well as referral to mental health services, these patients need supportive wound care and advice as to how to prevent or manage any infections. Ousey and Ousey (2010) have reminded practitioners that those patients who self-harm must have a holistic wound assessment that includes questions about their preferred treatments. It may be that patients will continue to delay wound healing, however if they are supported by the whole healthcare team, long-term harm may be avoided.

CHRONIC WOUND CARE

Where wounds have become senescent and are failing to heal, admission to a community hospital allows for the wound to be re-assessed and a differential diagnosis made. Drew et al (2007) suggested that up to one-in-three chronic wounds remained unhealed for at least six months, and one-in-five for a year or more. This is not to say that district nurses are unable to manage patients' wounds effectively; rather that placing patients in a more appropriate care setting means procedures can be undertaken more efficiently.

Chronic wounds can lead to:

- Increased risk of infection
- Psychological stress
- Impaired skin function
- Odour
- Reduced nutritional status
- Sub-optimal clinical and cosmetic outcome.

Cavity wounds

Cavity wounds are a common type of chronic wound that often develop as a result of pressure ulcers, diabetic

Figure 2. *A typical pathway of care.*

foot ulcers and, to a lesser extent, leg ulcers. The edges of cavity wounds must be protected, and dressings used to assist healing from the base of the wound upwards. This ensures that there is no 'undermining' around the wound edges and that the optimum tensile strength of the wound is achieved.

Cavity wounds can be managed effectively within a community hospital setting, either with the more traditional approach of lightly packing the wound space or by using topical negative pressure (TNP).

Dressing choice should be discussed with the patient and their individual health status taken into account. By following a logical pathway an updated plan of care can be achieved, which should enhance the patient's ability to move through to wound healing (Harding et al, 2007) (*Figure 2*).

PRESSURE DAMAGE

Pressure damage is known to be painful and distressing for patients as well as costly for the NHS, both in terms of occupied bed days and also in compensation payouts resulting from litigation (Bennett et al, 2004).

The introduction of SSKIN bundles within community hospitals demonstrated how planned interventions can make a significant difference to patients and the care they receive. SSKIN is the acronym for

- **S**upport surface
- **S**kin inspection
- **K**eep moving
- **I**ncontinence
- **N**utrition.

Figure 3. *A typical dehisced wound.*

An example of a typical intervention is ensuring that patients are nursed on supports surfaces that are appropriate for their needs — here the 'S' of the SSKIN bundle should act as a prompt for nurses to ensure that the patient is 'stepped-down' from an active mattress to a static foam mattress for instance.

Similarly, the 'K' for 'keep moving' is there to remind nurses that patients may require help with changing their position, and the frequency of this should be decided by the trained member of staff on each shift. For instance, a patient may require fewer changes of position during the day if they are undergoing physiotherapy or occupational therapy. This care bundle serves to ensure that key areas of care are covered to aid prevention in those patients who are at increased risk of developing pressure damage.

James et al (2010) reported a pressure ulcer prevalence of 26.7% across community hospitals in Wales — following introduction of the SSKIN bundle the rates subsequently fell (Keen and Fletcher, 2013).

However, in those patients who have already developed tissue damage, pressure ulcers can give rise to significant healing challenges for clinicians. Category two, three and four pressure ulcers all require extensive dressings due to loss of tissue, along with offloading — where the area is 'floated' using pillows or by supporting the leg with devices usually supplied via occupational therapy — as well as regular changes in position.

Supplementary dietary intake may also be required for those patients whose nutritional needs have been compromised.

Dressings can range from a simple hydrocolloid that might be used to cover a category two pressure ulcer (Fletcher et al, 2011), to the use of an alginate dressing covered with a secondary covering in a category four ulcer.

Adherence to local wound care formularies and working with tissue viability specialist nurses is crucial when trying to decide on the most appropriate product.

INFECTED SURGICAL WOUNDS

Surgical site infection (SSI) occurs within a wound following either keyhole or open surgery (National Institute for Health and Care Excellence [NICE] 2008), and is usually identified by localised pain at the wound site, heat, pyrexia and tachycardia (Cutting and White, 2005). SSI rates are closely monitored by infection prevention teams.

The first line of treatment in SSI is a course of antibiotics, however in severe cases the original surgical incision site may dehisce — this is where the wound itself has insufficient strength to withstand the forces placed upon it and the edges come apart (*Figure 3*) (Bale and Jones, 2006). This can happen at any time, but usually takes place between 6–10 days postoperatively and requires further surgical intervention, which may include debridement and reclosure or localised debridement with the wound then being left open to close by secondary intention.

This kind of intensive long-term treatment may not be appropriate in the patient's home and, particularly bearing in mind the increased cost of extra days spent in hospital (Coello et al, 2005), the community hospital could offer a safe and cost-effective alternative.

Many wounds that have dehisced due to infection present with a cavity, which needs to heal by primary intention from the base upwards. Once they have been packed and redressed daily, many dehisced wounds are then treated with TNP, which is able to manage the large volume of exudate associated with wound infection. TNP also facilitates rapid wound closure, as well as improving patients' quality of life by reducing the number of dressing changes.

Although in the past TNP was regarded as too expensive and only

Top tips:

- The choice of wound care product must follow comprehensive holistic wound assessment that involves examining the patients themselves as well as their wounds.
- Wound assessment must review all aspects of the wound, whether it is a linear surgical wound, a dehisced open cavity, leg ulcer or pressure ulcer.
- Before a wound can be successfully healed, any infection must be identified.
- Moisture balance is crucial to healing the wound — poorly managed exudate can increase the risk of infection and lead to the potential 'knock-on' effect of delayed wound healing.
- The role of patients in wound assessment is important — no one will understand a wound better than the patient themselves and in many cases they can provide an in-depth history.
- Debridement is essential in moving the wound along the healing continuum — tissue type should be identified and any devitalised tissue removed.
- Look out for comorbidities — previously diagnosed health issues such as diabetes are known to mask problems such as wound infection.
- The edges of cavity wounds must be protected, and dressings used to assist healing from the base of the wound upwards.

appropriate for the acute setting, once the cost of nursing time and patient wellbeing have been taken into account, the cost of TNP is outweighed by health gains. Thus, it is now widely used in community patients. Modern technology means that there are now smaller portable TNP machines that can deliver the negative pressure to the wound while allowing patients to continue with their rehabilitation.

CONCLUSION

Community hospitals are a growing service with staff working with colleagues in district general hospitals and treatment centres to provide a link between secondary and primary care.

With the support of visiting clinical staff from the acute sector and specialist nurses, community hospitals can offer a patient-centred approach to all aspects of care. As the age of the general population grows, so too will the pressure on services.

Community hospitals are ideally situated to ensure care needs are met and that discharge home is both safe and timely. Wound healing is a complex and at times lengthy process, which can be managed effectively within this care setting. JCN

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IN BRIEF

- This article discusses the impact of dementia in relation to the development of wounds.
- The author considers three wound types frequently seen in this client group — skin tears, pressure ulcers and moisture lesions.
- The article concludes that clinicians need to be increasingly aware of the impact of dementia and to provide appropriate care when wounds do develop.

KEYWORDS:

- Wound care
- Dementia
- Pressure ulcers
- Skin tears
- Moisture lesions

How does dementia affect patients with wounds?

Rosie Callaghan, Jola Merrick

Current research shows that in 2015 there were 850,000 people living with dementia in the UK (Alzheimer's Society, 2015). Dementia now costs the UK economy £26.3 billion a year, with this figure set to rise (Prince et al, 2014), and people over 55 are said to fear developing dementia more than any other disease (YouGov, 2014). To counter this, the government has identified dementia as a national priority, partly because one-third of people with dementia currently live in residential care (Prince et al, 2014).

Dementia leads to a progressive decline in memory and cognitive function, increasing functional impairment, and eventual death (Murray and Boyd, 2009). The Alzheimer's Society (2013) describes dementia as 'a set of symptoms that may include memory loss and difficulties with thinking, problem solving or language'; whereas the World Health Organization [WHO] (2015) describes it as a syndrome that is not part of normal aging and which affects cognitive abilities such as thinking, memory, understanding and emotions.

WHAT IS DEMENTIA?

There are many different types of dementia although Alzheimer's is by far the most common, being responsible for 60–70% of cases. It was first identified by Alois Alzheimer in 1906 but until the 1960s it was referred to as 'senile dementia'. Memory difficulties are often one of the first and most commonly recognised symptoms of Alzheimer's. However, there are many other types of dementia such as vascular dementia, dementia with Lewy bodies and dementia that affects the frontal lobe of the brain. Many people experience mixed dementia where more than one type is present at the same time.

Nutrition

Most people living with dementia lose weight as their illness progresses. (Ikeda et al, 2002). There are a variety of reasons for this, for example their cognitive impairment may affect their ability to recognise when they are hungry or thirsty, or they may have poor concentration or coordination meaning that meals and drinks remain unfinished. Muscles and reflexes are also affected, causing swallowing and chewing difficulties (Ratnaike, 2002), while damage to specific parts of the brain may mean that people start to like foods they did not like before or find foods they

THE SCIENCE — WHAT CAUSES DEMENTIA?

The different types of dementia have a variety of causes resulting from gradual damage to the brain. A build-up of abnormal proteins in the brain can lead to a decline in a person's mental and physical abilities. These abnormal proteins are different in each type of dementia. Neuron death is the main cause of dementia and is often related to malfunctions in the way that neurons 'communicate'. However, when the brain's immune system becomes too active this can cause inflammation, which can also damage cells. Unlike most cells, when neurons die other cells do not divide and replace them — this is why dementias are mainly progressive and irreversible.

Sources: www.nhs.uk; www.alzheimers.org.uk

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have always enjoyed distasteful. As their perceptions of taste and smell change, people often develop a preference for sweet food.

Communication problems can also mean that people with dementia are not able to express their dietary preferences and may spit out food they do not wish to eat or hold it in their mouths to be disposed of later (Morris and Volicer, 2001).

Depression is a common feature in dementia and is known to affect appetite — with one-third of over-65s and half of over-75s living alone (Age UK, 2015), there is a risk of social isolation as well as a lack of motivation to shop, cook and eat well.

Nutrition can have a serious impact on wound healing (Thompson and Fuhrman, 2005), with malnourished patients being at a higher risk of developing pressure ulcers and wound infections as well as having delayed wound healing (Stechmiller, 2010).

Mobility

People with dementia are often described as 'wandering'. Research, however shows that there is usually a reason for this — they may be bored, looking for the toilet or simply lost (Alzheimer's Society, 2013). It is also common for people with dementia to 'lose track', for example, they may have set off with a particular goal in mind, such as visiting the shops, but then forgotten their purpose.

Memory loss may cause people with dementia to forget that their walking ability is not as good as it once was and that they should be using a stick or a frame. This puts them at a much higher risk of falls than other older people — a problem accentuated by deteriorating spatial awareness and coordination as well as increased risk of postural hypotension. They are also prey to all the risks common to older people such as environmental hazards, poor eyesight, polypharmacy, pain and unsuitable footwear.

With the high risk of falls comes a high risk of injury — especially skin tears (see below). As dementia progresses and people's mobility declines, walking can become slower and the gait more unsteady, with some people becoming bed- and chair-bound. This immobility causes an increased risk of pressure ulcers (see below) (National Pressure Ulcer Advisory Panel [NPUAP], 2014).

A person with dementia may not remember where the toilets are or how to complete the task once they get there, struggling with clothing or arriving too late for example. This can lead to an increase in incontinence or inappropriate urination or defecation (Andrews, 2013). Incontinence can be very embarrassing and difficult to manage for people with dementia and their family and can lead to social isolation and stigma (Alzheimer's Disease International, 2012). As dementia progresses, control of bowel and bladder function may gradually be lost, leading to the risk of moisture lesion development.

Red Flag **Skin tears**

Risk factors for skin tears include:

- Age (older)
- Gender (female)
- Dry skin
- Fragile skin
- Comorbidities (diabetes, COPD, etc)

SKIN TEARS

A skin tear is a traumatic injury that occurs due to shearing forces or blunt trauma and causes the epidermis to separate from the dermis (partial-thickness wound), or both the epidermis and the dermis to separate from the underlying structures (full-thickness wound) (LeBlanc et al, 2011). Skin tears are most often sustained on the extremities such as the legs, arms and dorsal aspect of the hands (LeBlanc et al, 2011).

There are a number of risk factors for skin tears such as age (more common in older people), gender (more common in females),

Practice point

Protection is vital in maintaining skin integrity. Keep the skin well hydrated by maintaining nutritional intake and fluid balance. Patients with dry skin on their arms and legs will benefit from a twice-daily application of an appropriate pH-friendly moisturising cream.

dry fragile skin, and having comorbidities such as chronic heart disease or renal failure (Stephen-Haynes et al, 2011). Many skin tear risk factors — such as impaired mobility, poor nutrition or hydration, and cognitive impairment — may be directly associated with dementia.

Management

When a skin tear has been sustained, the main aims of management are to preserve the skin flap, approximate the edges of the wound if possible and reduce the risk of infection. Assessment should establish the type of injury as well as when, where and how it occurred (Cooper, 2006). Examination of the wound should be undertaken to determine the following:

- Location
- Dimensions (length, width, depth)
- Percentage of viable/non-viable tissue
- Degree of flap necrosis.

The skin tear should be categorised using a tool such as the STAR classification system (*Table 1*) (Carville et al, 2007).

The following steps should be taken when managing a skin tear

- Clean the wound
  - use saline to irrigate the wound and remove any debris. Apply pressure to the wound to control any bleeding
  - gently pat dry the surrounding skin to avoid further injury.
- Approximate the skin flap
  - if the skin flap is viable, gently ease the flap back into place and use the flap as a dressing. Record any approximation (Cooper, 2006)
  - for flaps that are difficult to align, consider using a

Table 1: The STAR classification system for skin tears (Carville et al, 2007)

Category 1a	Category 1b	Category 2a	Category 2b	Category 3
A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is not pale, dusky or darkened	A skin tear where the edges can be realigned to the normal anatomical position (without undue stretching) and the skin or flap colour is pale, dusky or darkened	A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is not pale, dusky or darkened	A skin tear where the edges cannot be realigned to the normal anatomical position and the skin or flap colour is pale, dusky or darkened	A skin tear where the skin flap is completely absent

moistened non-woven swab, applied for 5–10 minutes to rehydrate the area
- consider using wound closure strips to secure large skin flaps. Sutures and staples are not recommended due to the fragility of the skin
- apply a skin barrier product as appropriate to protect the surrounding skin.

- Apply the dressing
  - after securing the flap, select a suitable dressing such as a silicone foam and apply without tension, ensuring a 2cm overlap around the wound. A foam dressing with a film can be successful as it can be more difficult to remove for patients with dementia
  - the dressing should be appropriate for the category of the skin tear, wound characteristics, exudate volume and periwound condition (LeBlanc et al, 2011)
  - traditional adhesive strips should be avoided (Meuleneire, 2003). Consider gentle micro-adherent wound closure products where the skin is very fragile
  - if possible, leave the dressing in place for up to five days to avoid disturbance of the skin flap
  - mark the dressing with an arrow to indicate the direction of removal as per local policy. Use this arrow for direction of removal and record in the notes.
- Review and reassess
  - at each dressing change (i.e. every 3–7 days), gently lift and remove the dressing, working away from the attached skin flap. Consider using saline soaks or silicone-based adhesive removers to minimise trauma to the periwound skin (Meuleneire, 2003; Beldon, 2006)
  - when removing the dressing, take care not to disturb the skin flap
  - monitor for changes in the wound. Where the skin or flap is pale and dusky/darkened, it is important to reassess within 24–48 hours
  - observe the wound for signs of infection, including increased pain and exudate, redness, heat, oedema and malodour
  - use digital photography where possible to document the wound
  - adopt preventative skin care to avoid further skin tears.

How to prevent skin tears

Most skin tears occur during routine patient care activities such as lifting, washing or moving patients (Everett and Powell, 1994). Key strategies include creating a safe environment by:

- Ensuring adequate lighting and positioning small furniture (night table, chairs etc) to avoid unnecessary bumps or knocks. Remove rugs and unnecessary furniture
- Upholstering sharp borders of furniture or bed surroundings with padding and soft material
- Using appropriate aids when transferring patients and adopting good manual-handling techniques according to local protocols, e.g. slide sheets
- Never using a bed sheet to move the patient as this can contribute to damage by causing a 'dragging' effect on the skin (Beldon, 2006). Always use a lifting device
- Where possible reducing or eliminating pressure, shear and friction using pressure-relieving devices and positioning techniques
- Encouraging the patient to wear appropriate footwear and clothing to reduce the risk of injury
- Using clear signs to assist dementia patients with orientation
- Considering the use of pressure mats or other aids to alert staff when patients are on the move.

CARE OF THE SKIN AND PERIWOUND AREA

Protection is vital in maintaining skin integrity. Keep the skin well hydrated by maintaining nutritional intake and fluid balance. Patients with dry skin on their arms and legs will benefit from a twice-daily application of an appropriate pH-friendly moisturising cream (Hanson et al, 2005). It is important to:

- Avoid the use of soap, which can dry the skin. Use pH-friendly soap and cleansing solutions
- Apply emollients to moisturise and rehydrate dry skin
- Reduce moisture from incontinence or other sources
- Use a barrier film or cream to protect vulnerable skin
- Where adhesive products are used, consider a silicone-based adhesive remover to minimise trauma to fragile skin
- Protect fragile skin by covering with tubular or roller bandages, long-sleeved clothing etc.

PRESSURE ULCERS

Pressure ulcers can be defined as 'areas of localised damage to the skin and underlying tissue caused by pressure or shear and/or a combination of these' (NPUAP, 2014).

Age increases the risk of developing pressure ulcers and this risk is further increased by the diagnosis of dementia. This is due

Did you know:

Neuron death is the main cause of dementia and is often related to malfunctions in the way that neurons 'communicate'.

to several factors that are associated with dementia and the progression of the disease (*Table 2*).

When looking at pressure ulcer prevention within this group of patients, it is sometimes necessary to think 'outside of the box'. For example, the use of alternating mattresses for those patients with advanced dementia at high risk of pressure ulcer development is indicated in the NPUAP (2014) guidelines. However, when they are nursed on these surfaces, patients with advanced dementia can often experience restlessness and increased confusion, as they are unable to understand why the bed is moving underneath them. This means that they can constantly attempt to get out of bed. Similarly, an explanation of how this equipment works is difficult for them to understand and the information quickly forgotten.

In the authors' experience, it is far better to nurse these patients on a high-specification foam mattress and ensure that good skin care and position-changing regimens are consistently in place.

Hybrid mattresses with a foam outer casing and an alternating cell insert are also now available. The movement felt on this type of mattress is minimal and it is the authors' experience that patients sleep much better with these mattresses, and they can contribute to healing in pressure ulcers up to grade three.

Education and patient information for this group needs to be assessed on an individual patient basis (Kilroy-Findley, 2010) ensuring the format is relevant (i.e. in the correct language and in 'easy-read' if necessary). Where patients are unable to understand instructions, nurses need to assume responsibility for reminding or helping them to change position.

Top tips:

- People with dementia are prey to all the risks common to older people such as environmental hazards, poor eyesight, polypharmacy, pain and unsuitable footwear. With the high risk of falls comes a high risk of injury — especially skin tears.
- Nutrition can have a serious impact on wound healing — communication problems mean that people with dementia are not able to express their dietary preferences and may spit out food they do not wish to eat, or hold it in their mouths to be disposed of later.
- Many skin tear risk factors — such as impaired mobility, poor nutrition or hydration, and cognitive impairment — may be directly associated with dementia.
- Most skin tears occur during routine patient care activities such as lifting, washing or moving patients.
- Ensuring adequate lighting and good positioning of small furniture (night table, chairs etc) can avoid unnecessary bumps or knocks.
- Never use a bed sheet to move the patient as this can contribute to damage by causing a 'dragging' effect on the skin.
- Encourage the patient to wear appropriate footwear and clothing to reduce the risk of injury.
- Use appropriate aids when transferring patients and adopting good manual-handling techniques according to local protocols, e.g. slide sheets.

Table 2: Factors associated with dementia and their effect on wound development

Factor	Problem
Mobility	Difficulty in changing position or repositioning; declining mobility
Poor diet and hydration	Reduces the strength and healing capacity of the skin
Incontinence	Causes damage to the skin which can result in pressure ulcers if not treated
Poor blood supply	Conditions such as diabetes or vascular disease will increase the risk of ulcers
Agitation or restlessness	Friction on skin from clothes and bedding can cause shear and friction, especially over the elbows and heels
Medication	Can cause sedation and dry skin in some instances
Communication	Patients are not as able to express pain; non-verbal communication can be misinterpreted

INCONTINENCE-ASSOCIATED DERMATITIS (IAD)

Incontinence-associated dermatitis (IAD) is the clinical manifestation of simultaneous inflammation and erosion of the skin through prolonged exposure to various sources of moisture, including faeces, urine, perspiration and wound exudate (Gray et al, 2007) — these areas of skin degeneration are also referred to as moisture lesions.

IAD is most commonly experienced by people with faecal and urinary incontinence as this causes the skin's pH to become increasingly alkaline, resulting in skin irritation and breakdown (Langemo et al, 2011). Prolonged excessive exposure of the skin to moisture then leads to inflammation and dermatitis (Voegeli, 2012). If left untreated, symptoms include inflammation of the skin, redness and, in severe cases, swelling and blisters.

IAD can be located anywhere on the perineal area (except bony prominences — this would indicate

a pressure ulcer), and tends to be superficial, involving only the epidermis and upper dermal layers (NPUAP, 2014). IAD tends not to be localised, with the edges of any lesions usually irregular and the surrounding area reddened as a result of irritation through incontinence (Beeckman et al, 2010).

To prevent the effects of IAD it is recommended that a comprehensive holistic continence assessment is undertaken. Following this an appropriate skin-cleansing regimen should be adopted, incorporating the use of a suitable skin barrier product (Nix and Haugen, 2010). Mild cleansing agents and warm water should be used to clean the skin rather than soap, as this can have a drying effect and cause more irritation. The area should be dried thoroughly and moisturiser/emollients applied. The aim of treatment is to minimise exposure to urine/faeces, moisture and friction and a suitable barrier preparation should be applied as needed.

It is important to try and support people with dementia to remain continent for as long as possible. Simple strategies such as providing easily removable clothing (e.g. elasticated trousers and clear signage showing the location of toilets) can make a significant difference.

It can also be helpful for nurses to encourage the person with dementia to visit the toilet regularly by having a toileting regimen.

CONCLUSION

Nurses need to be increasingly aware of the impact of dementia and take steps to prevent the development of wounds and/or provide appropriate care when they develop.

The prevention and treatment of these wounds needs to follow an individualised holistic assessment, with nurses accepting that adjustments may need to be made to the treatment regimen to account for the person's dementia. JCN

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IN BRIEF

- The goal of palliative wound care is not necessarily wound healing, but relieving pain and other distressing symptoms.
- Palliative wound care involves psychosocial, physical and spiritual aspects of care.
- A team approach to care rather than cure will help to improve quality of life for patients and their families/carer(s).

KEYWORDS:

- Palliative wound care
- Skin care
- Wound management
- Assessment
- Patient-centred care

Palliative wound care

Jackie Stephen-Haynes

Management of palliative wounds is multifaceted and complex, as it involves not only treating the wound of a patient with a life-limiting illness, but also adopting an approach that includes family members, significant others and carers, as well as other members of the interprofessional team (Woo et al, 2015). In addition to having an understanding of wound healing, pain management, infection prevention and control, microbiology and pharmacology, clinicians need to address psychosocial factors and ethical issues to facilitate an evidence-based approach to wound management that corresponds with the principles of palliative care (*Table 1*).

This article focuses on holistic, person-centred care, exploring:

- Essential skin care
- The types of wounds in palliative care
- The importance of assessing the patient's clinical condition and managing exudate, maceration and excoriation, malodour, wound infection and bleeding.

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SKIN CARE

The skin is the largest organ of the body, making up 10% of body mass (White and Butcher, 2006). It acts as a barrier to the external environment, defending the body against infections and infestations and protecting it from irritants, ultraviolet (UV) irradiation and injury (Schofield et al, 2009). The structure and function of the skin reflects the cumulative effects of the naturally-occurring changes as skin ages, with it becoming less elastic, drier, with reduced tissue mass. The efficient function of the skin is often compromised in people whose mobility is restricted, i.e. those who are bed-bound, wheelchair users, or those unable to move or alter position often enough.

Patients with advanced illness are particularly at risk of skin damage, as decreased cutaneous perfusion and resulting localised hypoxia are acknowledged difficulties at the end of life (Sibbald et al, 2009). Furthermore, patients may have wounds directly as a result of their disease, such as cancer cells infiltrating the skin and causing fungating or malignant wounds (McManus, 2008).

Care of the skin is of prime importance, as if the skin is compromised it can have a dramatic effect on a person's wellbeing, particularly at the end of life (McManus, 2008).

> Palliative care aims to improve the quality of life for both the patient who has an incurable illness, and his/her family/carer(s) (World Health Organization [WHO], 2009).

Skin dryness may occur as a result of excessive washing or the use of alkaline soaps, which change the pH of the skin and reduce its barrier function (Wysocki, 2000). Using soap substitutes and emollient therapy can help to protect fragile skin and prevent pressure damage (British Dermatological Nursing Group

Practice point

The objectives of wound management in palliative care are to improve quality of life, control symptoms, promote confidence and a sense of wellbeing for patients and their families. Importantly, the principle is to promote a systematic and balanced team approach to palliative wound care.

Table 1: Principles of palliative care (World Health Organization [WHO], 2009)

It provides relief from pain and other distressing symptoms
It affirms life and regards dying as a normal process
It intends neither to hasten nor postpone death
It offers a support system to help patients live as actively as possible until death
It offers a support system to help the family cope during the person's illness and in their own bereavement
It uses a team approach to address the needs of patients and their families, including bereavement counselling, if required
It enhances quality of life, and can also positively influence the course of the illness
It is applicable early in the course of illness, together with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

[BDNG], 2012) (barrier products are further discussed below under 'maceration and excoriation').

Radiotherapy burns, that can occur in cancer patients, may be helped by the application of gels and specific foam products which contain moisturisers (Princess Royal Radiotherapy Team/St James's Institute of Oncology, 2011).

Pruritis, or itch, is sometimes seen in palliative care. This skin sensation can be distressing and have a negative impact on quality of life, with some patients even finding pain preferable to pruritis (Zylicz, 2004). It is a difficult symptom to manage and is largely unresponsive to antihistamines. However, tricyclic antidepressants may offer some relief, while non-pharmacological interventions, such as transcutaneous electrical nerve stimulation (TENS), are reported to offer some benefit (Grocott, 2007).

Skin inspection should occur on a daily basis, although changes noted in the patient's condition may increase or decrease the frequency. All findings from regular reassessment of the patient's skin should be documented and form part of holistic care. Educating patients and their families/carers about the significance of skin observation and reporting any redness promptly is also vital to help prevent skin breakdown (McManus, 2008).

WOUND MANAGEMENT

Care planning should be the result of thorough patient assessment, including psychological aspects, and consider:

- The patient's personal history, social circumstances and understanding
- Clinical assessment, i.e. the patient's illness, symptoms, treatment and current management
- Wound assessment, i.e. the site, size, tissue types present, condition of the wound bed and periwound skin, exudate, pain, odour, and bleeding
- The family's/carer's concerns, expectations, etc
- The patient's wishes, concerns and priorities.

WOUNDS TYPES

In the author's clinical experience, the two main categories of wounds encountered in palliative care are pressure ulcers and malignant wounds.

Pressure ulcers

Patients with palliative care needs are at significant risk of developing pressure ulcers (Stephen-Haynes 2014) as a result of:

- Increased age
- Reduced mobility and activity
- Poor nutritional status
- Exposure to friction and shear
- Exposure to moisture (Langemo et al, 2010).

Prevention of pressure ulceration includes risk assessment, re-positioning, nutritional assessment/management, continence management and the use of pressure-relieving equipment, including bed-bases, mattresses and cushions, to help minimise the negative impact that having a pressure ulcer can have on the patient's physical, emotional and social life (European Pressure Ulcer Advisory Panel/National Pressure Ulcer Advisory Panel/Pan Pacific Pressure Injury Alliance [EPUAP/NPUAP/PPPIA], 2014; National Institute for Health and Care Excellence [NICE], 2015).

Malignant wounds

Malignant wounds are caused by the invasion of skin tissues and supporting blood and lymph vessels by cancer cells (Pearson and Mortimer, 2004). These may be:

- Locally advanced
- Metastatic
- Recurrent.

As the tumour extends, the angiogenesis development of the blood capillaries becomes disordered altering the blood clotting mechanism within the tumour (Collier, 2000).

Grocott (2007) observed that primary cancers such as breast, head, neck, colon and penis more commonly fungate. Fungating breast cancer can appear as deep necrotic ulceration with proliferative growth of the ulcer margins, while cancer of the ovary, caecum and rectum, which infiltrate the anterior wall of the abdomen, present as small raised nodules, developing into necrotic 'cauliflower-like' structures (Grocott, 2007).

It is essential that care includes treatment of the underlying tumour, management of comorbid conditions, and symptom management.

Specific aspects relating to tissue viability in palliative wound care include maceration and excoriation, malodour, infection, bleeding and pain.

Maceration and excoriation

The nature of wounds occurring

Top tip:

The patient's comfort should always take priority over any wound care or measures to prevent skin breakdown.

in palliative care predisposes them towards maceration and excoriation, and care should focus on prevention.

Maceration is an indication of excess exudate, which has the potential to lead to skin breakdown and increase wound size (Cameron, 2004). It is caused by over-hydration of the wound and surrounding skin, which becomes saturated, white and friable (Cutting, 2003). The white discoloration is due to surface keratinocytes becoming overhydrated. Appropriate wound management and protection of the periwound skin will reduce the risk of maceration and further breakdown of the wound (Fletcher, 2002). Where the risk of exudate contamination of the periwound skin is likely or occurring, a skin barrier product should be used. This acts as an extra layer of epithelium, protecting the skin from breakdown (Stephen-Haynes and Stephens, 2013).

Excoriation is an inflammation of the periwound skin caused by an irritant, such as bacteria or destructive components in wound fluid, i.e. proteolytic enzymes in wound exudate. Matrix metalloproteinases (MMPs) are a group of proteolytic enzymes released from white blood cells which have a vital role in the autolysis of necrotic tissue, damaged collagen and elastin, through debriding and cleansing devitalised tissue. MMP activity is controlled by tissue inhibitor of matrix metalloproteinases (TIMPs). While in acute wounds MMPs and TIMPs are balanced, so that only devitalised tissue is degraded, in a chronic wound, such as those found in palliative care, MMPs become more prolific and TIMPs decrease, resulting in destructive exudate that causes skin damage and excoriation (Moore, 2003).

Thus, clinicians need to choose dressings that can manage the volume of exudate produced and continually assess their effectiveness, considering the frequency of dressing changes; leakage as a result of poor dressing fit (malignant wounds are often large and/or irregular in shape); and disturbance to patients, for example, when they are sleeping (Grocott, 1999).

Practice point

Malignant wounds are associated with a copious volume of exudate, particularly during the advanced stages or if the tumour is large (Selby, 2009).

Malodour

Malodour is recognised as having a negative physical and psychological impact on patients, in that it can reduce appetite and lead to social isolation and embarrassment (Fletcher 2008).

Assessing severity of malodour is difficult, as it is subject to an individual's own perceptions (Draper, 2005). However, it is important to consider the patient's views and the effect that a malodorous wound is having on their quality of life. Accurate assessment of the cause of malodour can contribute to a realistic management plan and should take into account if odour is evident:

- Only when the dressing is removed, i.e. close to the patient (slight)
- When the dressing is intact (moderate)
- On entering the room if the dressing is removed (strong)
- On entering the room when the dressing is *in situ* (very strong) (Haughton and Young, 1995).

If malodour is a significant challenge, a number of strategies can be used together, including personal hygiene and wound cleansing, the use of antimicrobial dressings or antibiotics, and the use of odour-managing dressings (Naylor, 2002; McDonald and Lesage, 2006).

In the author's clinical experience, aromatherapy may also be helpful, but should be used cautiously without oils being applied directly to the skin, as they can act as an irritant.

Bleeding

As a tumour extends, it may lead to blood vessels being eroded and an increase in the risk of spontaneous bleeding, or bleeding at dressing change, which is exacerbated by the decreased platelet function due to the tumour (Nazarko, 2006).

Practice point

Remember: patients' priorities should remain central to care planning, as wound healing may not be the ultimate goal. Although exudate management is important, if the patient is experiencing pain and breathlessness, frequent dressing or bed linen changes can become a further burden. Also, time spent on dressing or bed linen changes may be time that the patient would prefer to spend with their family.

Calcium alginates which exchange sodium ions with calcium ions thereby encouraging blood clotting are considered useful (Collier, 2000). Additionally, Grocott (2007) suggested the use of haemostatic surgical dressings. Bird (2000) noted the use of topical adrenalin 1:1000 in the form of a soak; although the vasoconstriction may cause ischaemia and necrosis. Naylor (2002) recommended caution when using adrenalin and that it should only be used under medical supervision. Reports of hospitalisation due to bleeding are reported by Lloyd (2008) and the prevention of bleeding due to adherent dressings or dressing removal should be a prime concern for those caring for patients with fungating wounds.

Wound infection

Patients who are receiving palliative care have an increased risk of infection due to their reduced ability to prevent and fight infection. In addition, as the skin may also be affected by decreased cutaneous perfusion and localised hypoxia, there is an increased risk of developing a wound, and, as the cellular balance with a chronic wound can lead to maceration and excoriation, the risk of infection increases (World Union of Wound Healing Societies [ ], 2007a).

Infected wounds are detrimental to patients' health, and can result in increased pain and deterioration in their general condition. Clinicians have a professional responsibility to implement universal precautions in infection control and to promptly

recognise the signs of infection and instigate and monitor treatment.

If a wound becomes infected, exudate volume increases, becoming viscous and potentially malodorous, with management focusing on treating the infection systemically or topically. Antimicrobial dressings may also be used. Although it is recommended that they are discontinued once infection has resolved and the exudate volume decreased (Wounds UK, 2013), in palliative care a decision may be made to continue the use of antimicrobial dressings or antibiotics, particularly where they are contributing to symptom management, such as lowering temperature, making the skin cooler and lessening exudate volume — all of which may make a positive contribution to the patient's comfort.

Pain control

The International Association for the Study of Pain (IASP, 1979) defined pain, highlighting its 'unpleasantness' and that it is both a physical and emotional experience. Importantly, pain levels can be improved when an early assessment is performed and preventative measures taken (WUWHS, 2007b).

Patients receiving palliative care may have more than one pain, and each may have a different cause. The types of pain relevant to wounds in palliative care are soft tissue, bone/muscle, and neuropathic pain. For soft tissue injury, the World Health Organization (WHO) analgesic ladder may be used (www.who.int/cancer/palliative/painladder/en/):

- Step 1: non-opioid +/- adjuvant
- Step 2: opioid for mild-to-moderate pain, +/- non-opioid, +/- adjuvant
- Step 3: opioid for moderate-to-severe pain, +/- non-opioid, +/- adjuvant.

The EWMA (2002) position statement established that the majority of pain experienced by patients with wounds was during dressing changes. Thus, it is important that clinicians choose dressings which minimise pain at dressing change and which can best manage the volume of exudate being produced, as this will help to reduce the frequency of dressing changes.

AIM OF WOUND DRESSINGS

As said, the overall aim of palliative wound care is to manage exudate, odour, pain, and bleeding (Adderley and Holt, 2014), thereby keeping the patient as comfortable as possible. Several modern wound management categories, including alginates, silicones and foams can help to achieve this aim.

Clinicians should consider several questions to guide their dressing choice (Stephen-Haynes, 2014), namely:

- Is the dressing conformable and comfortable?
- Is it suitable to be left in place for a long duration?
- Will the dressing prevent leakage between dressing changes?
- Does the periwound area need a preventative skin protector?
- Is it easy to remove?
- Is it easy to use?
- Is it cost-effective?
- What sizes are available?

When removing dressings, it is important to prevent pain, trauma, and bleeding, or cause any damage to the periwound skin. Where an adhesive dressing is used, a silicone adhesive remover may help with pain-free dressing removal (Stephen-Haynes, 2008).

CONCLUSION

Palliative wound care requires clinicians to consider several factors in relation to assessment, prevention, management and maintenance. By introducing effective wound management plans that reduce symptoms such as malodour, exudate leakage, pain and bleeding, clinicians can not only improve the patient's quality of life but also lessen the burden for family members who are caring for a relative who is dying. It is also important to provide information and offer practical and emotional support. Appropriate preventative strategies are also essential due to skin changes and decreased general health. The use of emollients, barrier protection, appropriate dressings and silicone medical adhesive removers can contribute to optimal care. Not only is this a professional responsibility (Nursing and Midwifery Council [NMC], 2015), but also a duty of care, and legal responsibility in Civil and Criminal law (Dunn and Leyshon, 2007). JCN

Practice point

Malignant wounds situated near major blood vessels can be at risk of severe bleeding (haemorrhage). Such bleeding can be extremely frightening both to patients and their families and, indeed, less experienced staff. Dark towels or blankets can mask the appearance of blood and having experienced healthcare professionals on hand can help to provide support in these situations.

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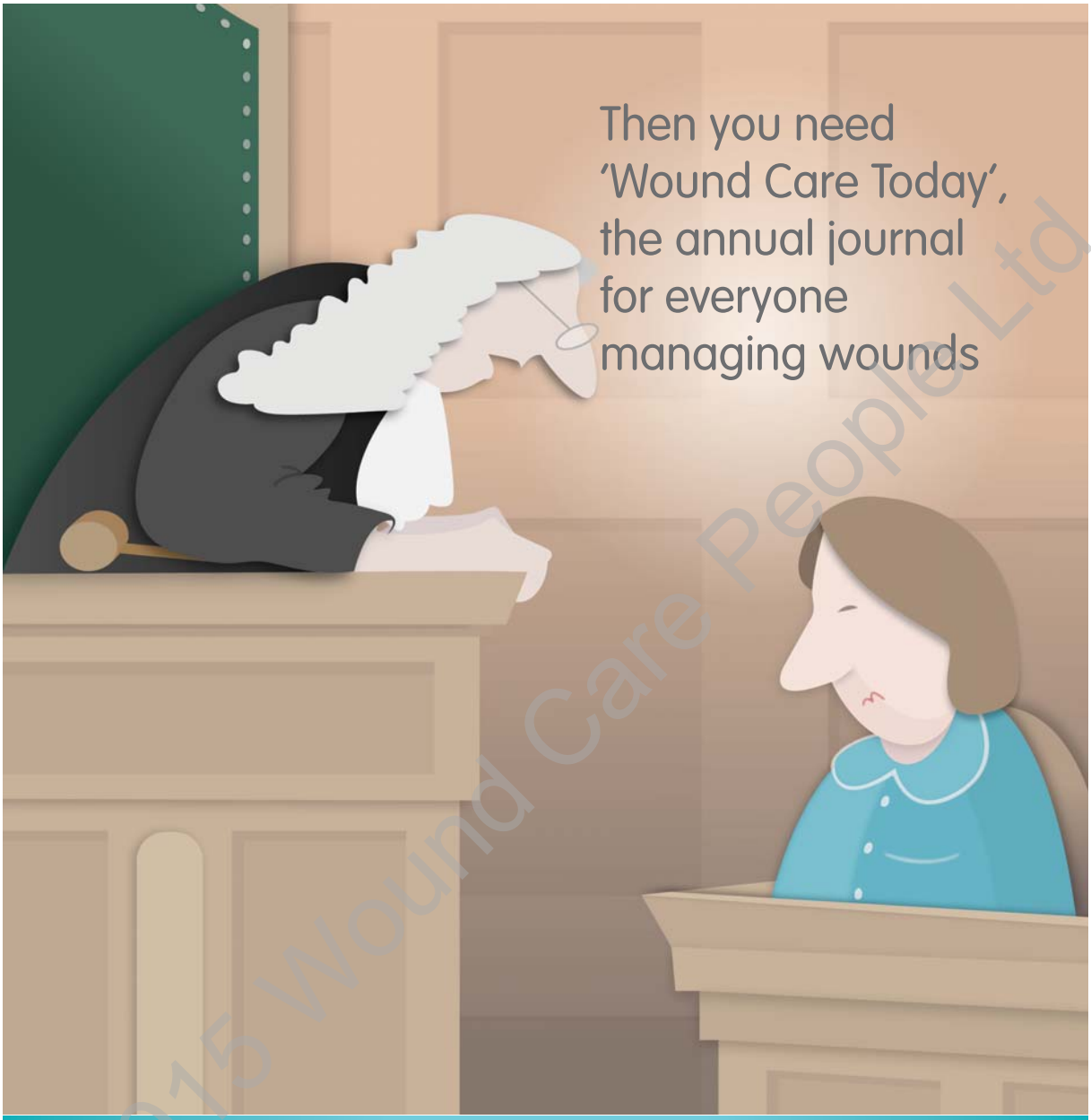

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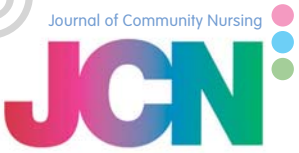

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