MDS Alert

CARE PLANNING: Cover These Bases When Providing Skin Care for Nursing Home Residents on Hospice

Check out these novel wound pain and odor management strategies.

The regulatory pressure for preventing and healing pressure ulcers may not be as tough when caring for hospice patients as in the non-palliative setting. But you still have to cover the bases to provide optimal care and sidestep F314 and other tags.

Key point: The regs and interpretive guidelines count skin breakdown as a deficiency if it's avoidable -- or if the facility fails to appropriately assess and treat an unavoidable pressure ulcer(s), says attorney **Joseph Bianculli,** in private practice in Arlington, Va.

To devise an individualized plan of care for the hospice patient that will also keep F314 and other tags at bay, consider these key strategies.

1. Think through the goals of care. Skin care in the palliative arena can be hard to differentiate from nonpalliative approaches, observes **Marygrace Lomboy, ARNP,** a nurse practitioner with Hospice of Lancaster County in Pennsylvania. If a hospice patient needs a wound vac due to wound drainage, that's appropriate, she notes. So is debridement to help prevent bacteria from embedding the wound and contributing to drainage or the "potential for infection," Lomboy adds.

Also keep in mind: "Preventing and treating pressure ulcers in hospice care is truly a quality of life issue" for the patient and his family, says **Lynn Serra, RN,** a hospice consultant with Carpenter and Associates in Lake Barrington, Ill. For example, if the resident has a malodorous, draining wound, "he may not be getting visitors or human touch."

2. Work with hospice to optimize outcomes. Lomboy partners with nursing homes to devise wound care plans for hospice patients in that setting. "We will do wound assessment and measurements with the nursing home nurses and brainstorm about what to do."

The Lancaster hospice skin-care protocol overall also includes use of advanced wound care dressings that can remain in place for three to five days, says Lomboy. And the hospice advocates use of draw sheets to lift a patient up in bed or help move or transfer the person. The hospice staff protects patients' skin from incontinence episodes by using calmoseptine, a moisture barrier cream.

Devices can help: "You can put a static overlay on the bed for a person who is low to moderate risk for skin breakdown, or use an alternating pressure mattress for people at higher risk," says **JoAnne Reifsnyder PhD, ACHPN,** program director of health policy for Jefferson University in Philadelphia.

3. Focus on pain and odor management. In addition to providing breakthrough pain medication prior to wound-dressing changes, if needed, the Lancaster hospice uses some "interesting palliative care approaches for wound pain," says Lomboy. For one, the pharmacy develops a topical spray for wounds that contains morphine, ketamine and bipivicaine. "And we have a mor- phine gel that we can put in the wound bed."

To combat wound odor, Lancaster Hospice care staff may get an order for metronidazole (Flagyl) and clindamycin (Cleocin) powder to put in the wound. "And we may put charcoal or kitty litter under the bed -- and essential oils like lavender near the bed," she adds. Sometimes you can control odor by using an advanced wound care product that controls the wound drainage, Lomboy adds.

4. Assess and address why a patient refuses skin care. If the resident refuses repositioning or basic wound care, don't just chalk it up to the fact that he's terminally ill. You can bet surveyors won't. For example, asks Serra, "is the person depressed, angry, or in pain? Does he not have enough meaningful activities to engage him in a quality life?" If the latter is the case, the hospice can bring in music therapy, pet therapy, and volunteers to visit, Serra suggests.

5. Educate the family. Sometimes families "feel a tremendous amount of guilt and emotional suffering when their loved one develops a pressure ulcer," Lomboy observes. Yet a lot of different studies show that "up to 19 to 25 percent of palliative care patients who die will have some type of bedsore. That's a big piece of the population -- and not all of it's related to poor care." To help allay family members' emotional burden, Lomboy explains to them that the skin is the largest organ in the body and can fail when the person is near death. "We may see the Kennedy ulcer in the sacrum develop 24 to 48 hours before the person dies," she adds. "And that's basically a result of organ failure."

Education pays: "We care for a lot of Amish people and they do a fabulous job of taking care of their family members," Lomboy notes. And the Amish caregivers said that learning that the skin can fail no matter what "lifted a big burden for them."