The Healer

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PRESSURE REVISITED

From the Editor

Teresa Matthews, FNP-C, CWCN, RN

This issue of The Healer builds on the Pressure Theme. However, I have chosen to focus on the end of life changes with skin. Frequently, I have forgotten that the skin is the largest organ of the body, and subject to the same failing mechanisms that the other organs experience. I have enjoyed researching the Kennedy Terminal Ulcer phenomenon and am amazed at how much I have learned. This ulcer signals impending end of life. What is more amazing is WHY this is so important. When we have residents in long term care, they may be receiving physical therapy, advanced treatments and medications, prolonged interventions and surgeries, etc. But when we accurately diagnose a Kennedy Terminal Ulcer, it may be time to shift our goals to a more palliative situation. Adjusting the patient to a care plan of comfort may be more beneficial than continuing a harsh regimen of interventions. It allows more acceptance from family, as they can now visualize the heralding end of life fact, vs. an abstract view and unrealistic hope.

Another important aspect of end of life situations revolves around the "Avoidable" vs. "Unavoidable" pressure ulcer debate. A Kennedy Terminal Ulcer is unavoidable. Accurate diagnosis assists in state regulatory issues when assuming responsibilities for the wound's origination. However, avoidable or not, appropriate interventions must follow, and if they are not, state interventions will not be pleasant.

By request. this issue includes an encore presentation of the Deep Tissue Injury article. There is a lot to still be learned in this wound presentation. I truly believe the more we read about it, the more pictures we view, and the more understanding we gain will ultimately benefit our precious elders as they reside in our care.

Our Featured Author is Catherine Priem. Cat is an outstanding nurse and futuristic patient advocate in the long term care setting. She is a corporate consultant, and shares her vital experience in chart reviews to help us all with our documentation. We have a lot to learn from her, and hope to feature her in the future as well. Her future is bright, endless, and will leave many historic footprints in the profession of nursing.

Valerie Graham is a true example of a nursing leader. She regularly provides me with tips on wound care. These tips are easy to remember, include common sense, and a touch of humor. Val's positive attitude, advanced education, and vast experience will hopefully appear in many future issues of The Healer. She is destined for greatness, and I am quite honored to have her as my friend.

Sit back, get a cup of tea, and enjoy this issue. I welcome feedback at advanced_healing@hotmail.com. We have always been taught that no one knows when the end of life will occur. We are now blessed with knowledge of a sign, which helps in so many different ways. I would love to hear everyone's experience with the Kennedy Terminal Ulcer, as well as how knowing this will change your practice.

IN THIS ISSUE

Teresa Matthews is the proud owner and sole Nurse Practitioner for Advanced Healing, Inc. She proudly organizes wound rounds at Delaware's long term care facilities, and educates our providers on the honor of caring for our tender elders. Along with house calls and public speaking, this unique practice is endless in possibilities. Teresa earned her MSN from Wesley College and her Post Masters Family Nurse Practitioner from Indiana State University. She is Certified as a Family Nurse Practitioner through AANP. Teresa welcomes comments and offers individual encouragement through www.advanced-healing.net or at her office at (302) 363-5839.

The Kennedy Terminal Ulcer

Teresa Matthews, FNP-C, CWCN, RN

The Kennedy Terminal Ulcer is an unavoidable skin breakdown or skin failure that occurs as part of the dying process. Research is limited but the literature suggests that these ulcers are typically pear-shaped, red/yellow/black, similar in appearance to an abrasion, and tend to occur suddenly in the sacral/coccygeal region. This occurs not long before death of the patient. Research about end-of-life phenomena such as skin failure is needed to help clinicians, caregivers, and patients understand what is occurring and facilitate the provision of optimal and appropriate end-of-life care. Shifting the goals from that of rehabilitation to that of palliative care can make the difference in the quality of life, and comfort for the patients as well as peace for their families.

Patients nearing death may experience a phenomenon known as the Kennedy Terminal Ulcer (KTU). The skin breakdown in the sacral/coccygeal area was first noted by Karen Lou Kennedy, a registered nurse, and other healthcare workers at the Byron Health Center, an intermediate care facility in Fort Wayne, IN, in 1983. This team found it amazing that the ulcers occurred despite meticulous preventive measures. Skin deterioration progressed rapidly, even in the course of a single day. Caregivers and family members were surprised at the sudden onset. It was concluded by the Byron staff that this type of ulcer heralded impending death. (Kennedy 1989).

The KTU is described as a pear-, butterfly-, horseshoe-, or sometimes irregular-shaped red/yellow/black ulcer, similar in appearance to an abrasion or blister that typically occurs suddenly. The blister roof may be very fragile. Even gentle cleansing may change the skin surface from intact to a fairly large open wound. The ulcer may darken quickly before demarcating within days. It has the characteristics of early deep tissue injury and can progress rapidly to a Stage II, Stage III, or Stage IV ulcer. Sometimes the surrounding tissue is soft or loose beneath the surface. Time is a key factor. Pressure ulcers in general can develop within 24 hours of skin insult and take as long as 5 days to present. According to Kennedy and others, Kennedy Ulcers come on quickly and progress rapidly, often within hours.

Initially, the Kennedy Ulcer was thought to be located exclusively in the sacral/coccygeal area; this was later amended to be described as its usual location. Kennedy Ulcers have been known to appear on the heels, posterior calf muscles, arms, and elbows. Early descriptions compare the look of the buttocks in some cases to being dragged over a black-topped road.

A Kennedy Ulcer has been found to be a pressure ulcer that heralds the end of life. The velocity of skin organ failure can be alarming. The Kennedy Ulcer can occur within hours, leading to the 3:30 Syndrome. The Byron Health Center in Fort Wayne, Indiana, a 500-bed long-term care facility first described the 3:30 Syndrome. (Kennedy 1989). It can come on quickly, sometimes in a matter of hours. It may begin as little spots that are black. They tend to look like a speck of dirt or dried bowel movement most caregivers tend to try to wash away, finding out it is under the skin and not on the skin. These can look like suspected deep tissue injuries. As the hours continue, it becomes larger and can in a matter of hours become almost the size of a quarter, fifty-cent piece or silver dollar. These can look like someone colored the skin with a black or purple marker. It quickly can present as a black flat type blister with intact skin presenting in a unilateral location. The usual story is the patient got up in the morning the skin was examined by the nurse aid and the skin looked normal and was intact with no discoloration. At 3:30 PM when the patient was placed back in bed the skin shows this blackened discoloration. (Thus the name: 3:30 syndrome.) When the nurse comes to examine the discolored skin it is difficult to believe it actually was not here in the AM and is as large as it is 6-8 hours later. The life expectancy of the 3:30 syndrome presentation of patients is usually within 8-24 hours.

The Skin Changes at the End of Life (SCALE) consensus document developed by an expert international panel in 2009 was particularly useful, providing her with insight that she now shares with professional colleagues and families. (http://woundpedia.com/pdf/SCALEAbstractPanelMembersStatements.pdf. 2009). Noting that the skin is the body's largest organ, experts in the field wrote that understanding of alterations in skin integrity near the end of life is limited and that those changes are insidious and difficult to predict. Contrary to popular belief, the group stated, not all pressure ulcers are avoidable. The panel concluded that more research is needed to establish causative factors, identify the specific pathophysiology around skin deterioration, establish diagnostic and clinical criteria for skin changes at the end of life and create evidence-based pathways to guide clinical care. When signs of organ failure become evident, it may be time to consider hospice placement. Daily rounds in patient care areas offer the opportunity to discuss end-of-life concerns with nurses, physicians, case managers and social workers.

What are the best options for a particular patient who is showing signs of skin changes and other organ failure? Are we guiding families appropriately in terms of end-of-life decisions? This writer suggests opening a dialogue, showing family members the changes in skin integrity and discussing their implications, encouraging them to do what's best for their loved one in terms of quality of life and medical care.

Families do understand that the skin is a dying organ. Families also understand that pressure ulcers are painful, and is not a comfortable way to die. Once body organs begin to fail and we see changes in the skin integrity, the body may no longer metabolize food or tube feeding. This change is a normal party of the journey at the end of life. (Tippett, 2001).

Nurses can also be comforted by this evidence-based information. Needless surveyor deficiencies regarding a facility acquired pressure ulcer that is actually a Kennedy Ulcer only adds to the frustration of caring for end of life patients. In spite of all best efforts in pressure redistribution and intervention, the skin is an organ that begins to die. It is not a failure in nursing care, but rather a natural part of the dying process. When we see the stages of pressure ulcers developing, we can do the best we can to prevent worsening, and refer the patients to appropriate levels of care to promote dying with dignity.

Practice pearls

* Some skin changes, including Pressure Ulcers, at the end of life are unpreventable.

* Physiologic changes that occur as a result of the dying process may affect the skin and soft tissues and may manifest as observable (objective) changes in skin color, turgor, or integrity, or as subjective symptoms such as localized pain.

* The plan of care and patient response should be clearly documented and reflected in the entire medical record.

* Patient-centered concerns should be addressed, including pain and activities of daily living.

* SCALE is a reflection of compromised skin (reduced soft-tissue perfusion, decreased tolerance to external insults, and impaired removal of metabolic wastes).

* Expectations around the patient's end-of-life goals and concerns should be communicated among the members of the interprofessional team and the patient's circle of care.

* Risk factors, symptoms, and signs associated with SCALE may include suboptimal nutrition, including loss of appetite, weight loss, cachexia and wasting, low serum albumin/prealbumin levels, and low hemoglobin, as well as dehydration.

* A total skin assessment should be performed regularly and all areas of concern should be documented consistent with the wishes and condition of the patient.

* Consultation with a qualified healthcare professional is recommended for any skin changes associated with increased pain, signs of infection, skin breakdown (when the goal may be healing), and whenever the patient's circle of care expresses a significant concern.

Continued on Page 3

Kennedy Ulcer: Continued from Page 2

* The probable skin change etiology and goals of care should be determined.

* Patients and concerned individuals should be educated regarding SCALE and the plan of care. (Langemo, EK 2006).

Skin is the largest organ of the body and is as susceptible to failure as any other organ system; it is not logical to expect healing of skin to occur while other organ systems are failing. The goal in hospice is always to provide comfort, relieve suffering, and improve the quality of living and dying. A dedicated effort is needed to define palliative wound care. Using an interdisciplinary approach with input and feedback from nurses, physicians, aides, and family caregivers, a palliative wound care protocol for prevention and treatment can be developed using simple, inexpensive products and techniques. The goals of wound care include the following:

• Relief of pain. First and foremost, the absolute necessity of the entire program. Without this step, we cannot progress to the next steps.

•Prevent worsening, through meticulous pressure redistribution, realizing that these efforts may not be successful.

•Elimination of odor.

•Maintenance of Function. If the patient wishes to be up in a chair, or resting in bed, the pain management and dressing choices can collaborate with the functional desires of the patient.

•Healing, when possible. However, if healing occurs, it is a quality of life indicator, and not a specific goal of treatment.

Part of developing a palliative program involves defining the magnitude and scope of the problem. Wounds are a known problem in the elderly population with 10–25% of nursing home residents reported to have pressure ulcers, but there is little information on wounds at the end of life. (Rhodes, 2004). What is the magnitude of the problem? How many wounds are occurring at the end of life, and what types of wounds are occurring? How severe is the problem at the end of life? Is it the 10% estimated by local hospice administrators? There is scant published data, and research is needed. Who has wounds, and what can be done? Is it realistic to expect healing of wounds as is the traditional approach to wound care and wound treatments? Or should palliative care with different goals and treatments than traditional care be instituted?

We love our patients. While we are programmed to heal, this is a time to set aside the need to heal, and to return to the origins of nursing. Comfort. Relief of suffering. Compassion. It is a serious blow to the meticulous wound nurse who prides their ego on the ability to heal the most problematic wounds. To have these wounds develop in spite of the constant care and pressure redistribution efforts is disheartening. Add that to the mandatory reporting of nosocomial pressure wounds and there is an added misery. Educating the staff, physicians, surveyors, and especially the family on the unavoidable wounds from skin organ failure may empower us to continue our diligence in the care of our patients. Too many wounds are being classified as avoidable, leading to needless litigation and anger from the families who have suffered enough.

Kennedy Ulcers are unavoidable. These patients need palliative care. They do not need debridement, continued rehabilitation, peg tube placement, full-code status, etc. Recognizing the Kennedy Ulcer will be the greatest gift you can give your patient. Realigning their goals with that of end of life comfort will bring peace to these precious souls, and to their families.

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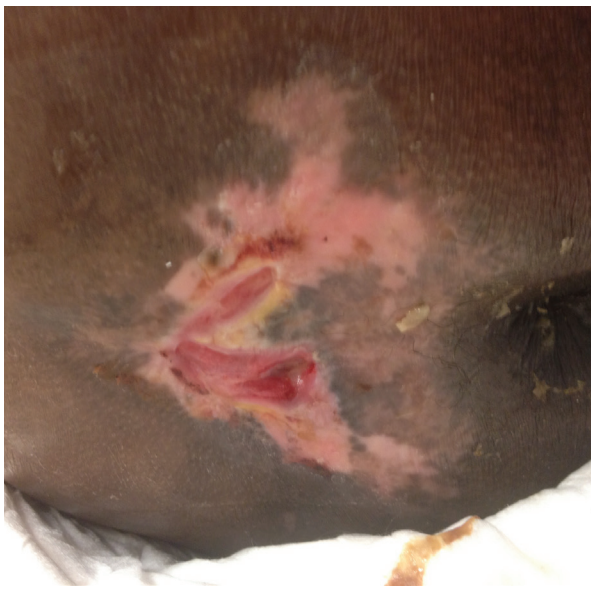

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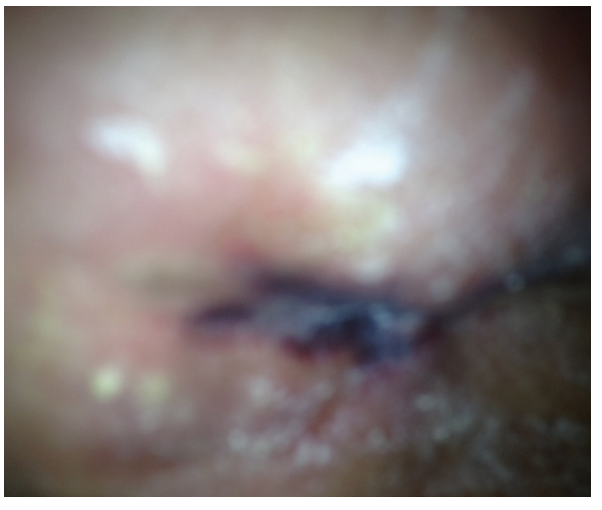

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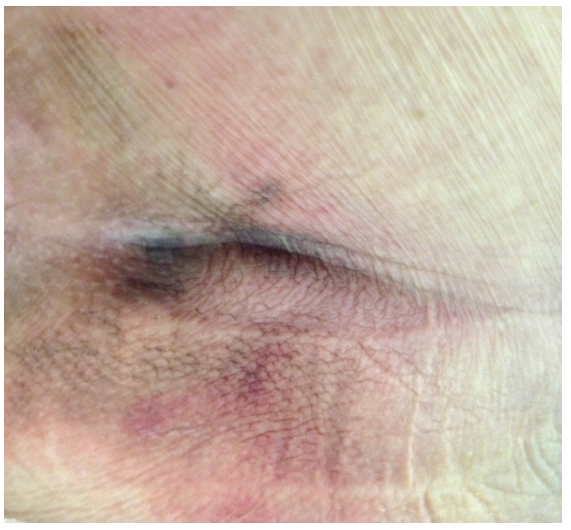

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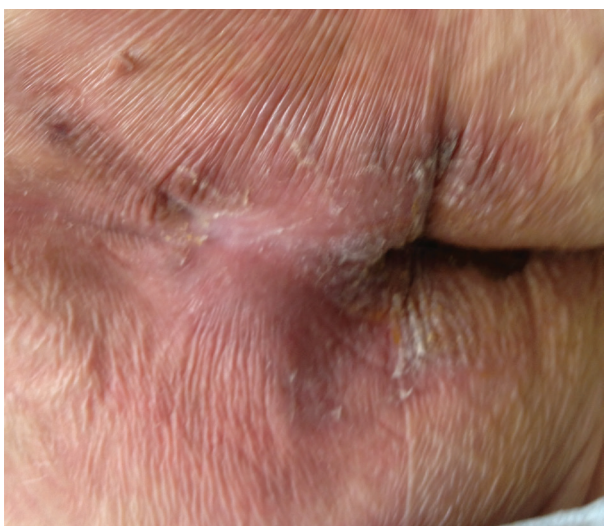

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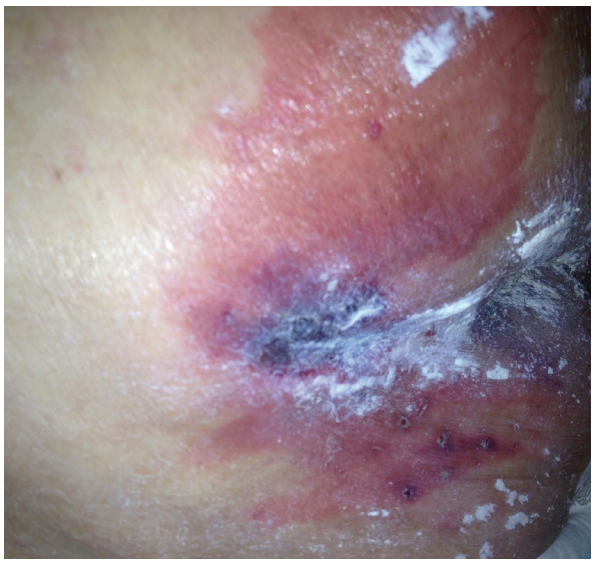

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Long Term Care

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Advanced Healing

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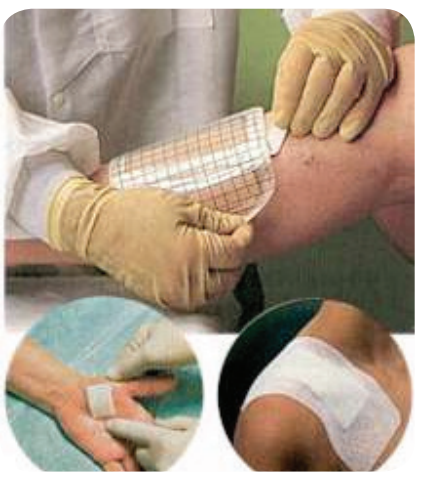
Advanced Healing, makes regular, scheduled weekly visits to each participating nursing home for treating new and established wound patients. The weekly visit is meant to supplement, not replace, the daily wound care provided by the nursing home.

Following each visit, Advanced Healing will provide the nursing home with written follow-up care recommendations for each wound for the coming week. Whenever possible, these recommendations will take into consideration the dressings and supplies available in the nursing home's formulary.



Advanced Healing can become an integral part of a healing program. Through thorough clinical documentation that complies with Medicare and state regulations, Advanced Healing will provide a complete weekly evaluation. This includes suggested treatment plans, Medicare approved product protocols, pain management, and bedside debridement, if indicated. This will save costly transportation fees to local wound care centers. Collaboration with physicians, dieticians, physical therapists, and other holistic practices will complete the treatment plan. By billing Medicare and insurances directly, there is no cost to your facility.

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A Higher Level Of Health

Valerie Graham , BSN, RN

Valerie Graham holds a BSN from Salisbury University. She has worked in public health specializing in communicable diseases and epidemiology. She worked at the Centers for Disease Control with infectious diseases and public health practices. Upon returning to Delaware in 2011, she began working at the acclaimed Delaware Veterans Home in Milford as a nursing supervisor, infection control, and wound care nurse. She is obtaining her Masters in Nursing degree from Grantham University, and will celebrate her graduation in April, 2013. Her Major Applied Research Project is appropriately centered on wound care, and she seeks her CWOCN certification as well as the CIBC exam for Infection Control Certification. She is happily married with two beautiful five year olds: Thomas and Janeka. Thomas and Janeka were adopted as infants from Guatemala, and they are the lights in the lives of the Graham family. They lead Val to pursue further education to provide a better life for them, as well as displaying a role model in which they can excel. Her work at the Delaware Veterans home led her to meet Teresa Matthews, her inspiration. Wounds have always been Val's topic of choice, and with Teresa as a teacher, she wants to learn more each day. To quote Val: "Thanks, Teresa, for being such a wonderful teacher and friend!"

This and That

Hand Washing Facts: Could singing Yankee Doodle save your life?

submitted by: Valerie Graham, BSN, RN.

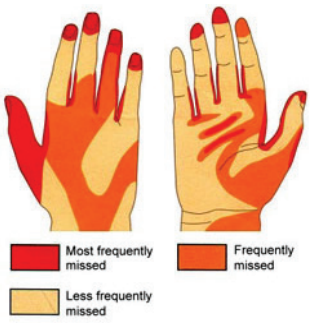
1. 80% of all infectious diseases are transmitted by touch! According to leading experts, the single MOST important thing you can do to prevent illness is TO WASH YOUR HANDS.

2. The SOLLUTION TO POLLUTION IS DILUTION!
While soap may not kill all viruses, through hand washing will decrease the number of bacteria present to a point below the infectious threshold.

3. Caught in the act (or lack of). 95% of the populations say they wash their hands after using a public toilet. However, when 8,000 people were monitored across five large cities in the USA, they found the actual number to be more like 67%!

4. Do as I say, not as I do……
A poll of ICU physicians showed they claimed their rate of hand washing between patients was 73%, but when followed and observed, the hand washing rate was found to be less than 10%. Do not claim you are too busy, and your hands will dry out----DO IT ALWAYS!

5. Where is the dirt?



CDC studies show the number of bacteria per square centimeter on the human body are as follows:

*Scalp- 1,000,000
*Forearm- 10,000
*Arm pit- 500,000
*Abdomen- 40,000
*Hands of Medical personnel- 40,000 to 500,000

(When it comes to fingernails and the surrounding areas harbor the most microorganisms,

If you have artificial or overlays on your nails, the bacteria is even worse, and hand

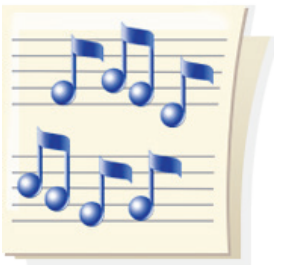
Washing with hand sanitizer and soap do NOT decrease the number of the bacteria.)

6. Too busy?
Studies have shown that hand washing guidelines were followed 25% of the time during times when the floor was overcrowded and under staffed. Compliance rose to 70% when the floor was properly staffed. DVH maintains a BETTER than average staffing ratio on all units, all shifts, so make sure you follow guidelines and recommendations for hand washing.

7. And the winner is……
Many studies show that alcohol rubs are more effective then plain or antimicrobial soaps, unless the hands are visibly soiled.

8. How long is enough?
The CDC recommends at least 20 seconds, however studies show that the reduction of skin bacteria is nearly TEN times greater of you wash for 30 seconds, rather than 20!

Children are taught to sing "Yankee Doodle Dandy" start to finish before rinsing, why not adults too? If you do not know the words to this song, the Happy Birthday song sung twice will suffice.



9. Some like it hot.
But if they do, hot water can increase the chance of skin dryness and dermatitis. Hot or warm water has not been proven to increase effectiveness of hand washing. Cold water, though not as comfortable, produces less skin damage from detergents especially with repeated washings.

10. The two layers of bacteria.
The outer layer of bacteria found on your hands is termed "Transient Flora"-this layer is potentially the most dangerous for transmitting disease from one person to another. Fortunately, it is the most easily eliminated by hand washing.
The deeper layer is called "Resident Flora"-this bacteria population is more likely to be made up of innocuous bacteria as Staphylococcus epidermis and Corynebacteria spp. (diptheroids), and is more resistant to washing, since they are in the deeper layers of skin.

Editor's note: Thanks, Val, for you are my teacher and, most importantly, my friend!

Suspected Deep Tissue Injury

Encore Presentation

Teresa Matthews, FNP-C

Suspected Deep Tissue Injury has become an official stage in accordance with the National Pressure Ulcer Advisory Panel. The following is a direct statement update from the NPUAP in February, 2007.

Pressure Ulcer Stages Revised by NPUAP

February 2007 - The National Pressure Ulcer Advisory Panel has redefined the definition of a pressure ulcer and the stages of pressure ulcers, including the original 4 stages and adding 2 stages on deep tissue injury and unstageable pressure ulcers. This work is the culmination of over 5 years of work beginning with the identification of deep tissue injury in 2001.

The staging system was defined by Shea in 1975 and provides a name to the amount of anatomical tissue loss. The original definitions were confusing to many clinicians and lead to inaccurate staging of ulcers associated or due to perineal dermatitis and those due to deep tissue injury.

The proposed definitions were refined by the NPUAP with input from an on-line evaluation of their face validity, accuracy clarity, succinctness, utility, and discrimination. This process was completed online and provided input to the Panel for continued work. The proposed final definitions were reviewed by a consensus conference and their comments were used to create the final definitions. “NPUAP is pleased to have completed this important task and look forward to the inclusion of these definitions into practice, education and research”, said Joyce Black, NPUAP President and Chairperson of the Staging Task Force. (National Pressure Ulcer Advisory Panel website, 2007)

Pressure Ulcer Definition

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated.

Pressure Ulcer Stages

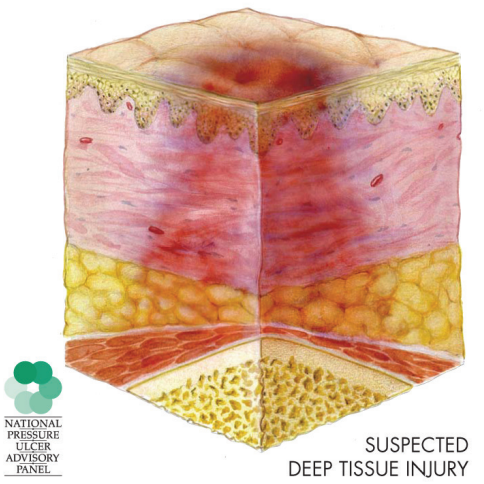
Suspected Deep Tissue Injury:

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Further description:

Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. (http://www.npuap.org/pr2.htm).

An anatomical visual aid of Suspected Deep Tissue Injury:

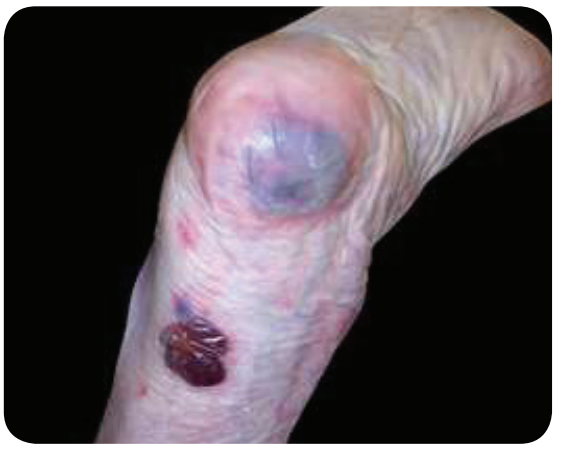


(National Pressure Ulcer Advisory Panel Website, 2007)

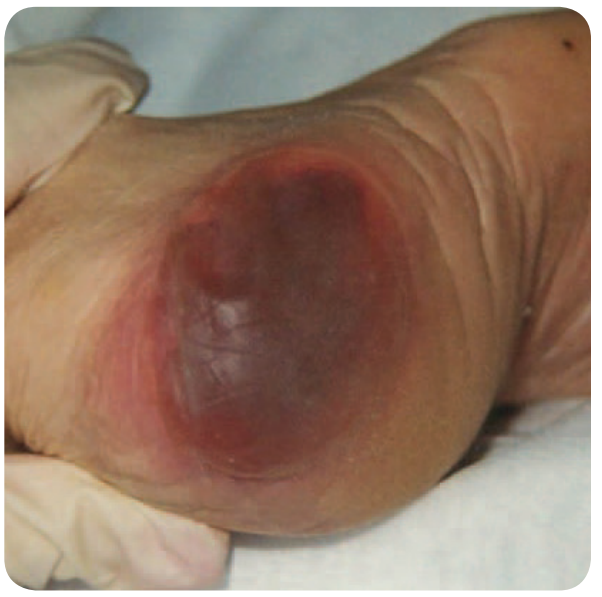
This becomes a valuable assessment upon admission. Long term care facilities are particularly concerned with facility acquired pressure ulcers. On admission, an assessment described as above would warrant a community acquired pressure ulcer of Suspected Deep Tissue Injury. Pearls to remember during assessment include:

- Damage to deeper structures has already occurred
- Skin may still be intact because of its higher resistance to hypoxia
- Heralding sign of an impending stage III or IV

Tissue injury that appears dark discoloration, deep bruising, or hematoma is Suspected Deep Tissue Injury. Borders are generally irregular. Hemorrhage and clotting occur as a consequence of an acute injury, such as trauma from pressure or shearing. Clotting cuts off oxygen to the tissues, with hypoxia and ischemia following. It is not known exactly how long clotted blood can remain in the tissue before cellular death occurs. Typically, stage I pressure ulcers are considered minor wounds that are likely to heal with pressure redistribution. A suspected DTI potentially caused by reperfusion injury may not respond to offloading. If the blood is not reabsorbed into the tissue in a timely manner, necrosis will occur. (Touch Briefings Website, n.d.)



(Wound Educator website, n.d.



(Touch Briefings Website, n.d.)

Heels present an especially common area for deep tissue injuries to develop. The skin of these ulcers tends to present with a purple or ‘bruised’ look to them.

In summary, accurate assessment of Suspected Deep Tissue Injury on admission can initiate necessary interventions. These wounds are likely to deteriorate, and prompt identification can prevent the occurrence of a facility acquired pressure ulcer. Of highest importance, however, is the immediate treatment protocols that are set in place for a serious wound issue. Implementing offloading and evaluating the efficacy of the interventions will promote the healing of suspected deep tissue injury.

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Nosocomial or Community: Determination with Documentation

Catherine Priem, BSN, RN

Do you cringe when you hear the term "nosocomial wound?" Do you relax slightly when you hear "hospital acquired wound?" This is a normal response in this day of nursing. However, you should cringe even more when you find out your facility's documentation, or lack of documentation, made it a nosocomial wound instead of a community acquired wound. (Stewart, 2004).

A community acquired wound is a wound that has developed outside of the facility prior to admission. Also, a community acquired wound can occur during a leave of absence, such as a day-long trip to dialysis. Patients who frequently attend out-of-building treatments would benefit from a skin assessment prior to leaving, and immediately upon return.

A nosocomial wound is a wound that has developed within the present facility. Documentation is the key in your investigation to determine the wounds classification of origination. Red heels upon admission are frequently the first clue that a community wound may be developing. These heels may actually be suspected Deep Tissue Injury that originated prior to admission to the long term care facility. Appropriately documenting skin condition, interventions, and overall health status is vitally important when investigating wounds. (NPUAP).

Skin condition should be documented many times throughout the patient's stay. Of course, we all know to check skin on admission, re-admission, and weekly, but that might not be enough. Encouraging nurses to think outside the box when it comes to assessing skin has induced the critical reasoning required in this serious situation. The following are just a few examples of situations requiring an additional skin assessment:

- Has your patient had a respiratory infection and is now deconditioned? This flu season has left several long term care residents weakened and spending more time in bed
- . As your patient nears the end of life, remember skin is an organ. It can fail, much like other organs of the body.

Ensure these extra skin checks are documented in the medical record and if anything different is noted, your staff knows how to notify the appropriate parties. The family should be notified, as well as the Medical Director, and your skin specialist. Close monitoring of skin condition will allow for changes in interventions to help prevent breakdowns.

Typically on admission, standing skin interventions are ordered for the resident. They may include turn and reposition every two hours, house lotion after care, and off loading of heels. These interventions are good, but the documentation must match. If you order "offloading of heels", but your flow sheet is not reflective, the subsequent deep tissue injury to the heel is now your nosocomial wound. (Frain, R, 2008).

Not all patients will benefit from the same interventions. Use your interdisciplinary team to brain storm different interventions that will help that unique patient. Occasionally, even with all the interventions in place you may still have skin breakdown. Considering the patient's overall health status is equally as important.

When a patient's overall health status is declining, documentation of labs, interventions, and the expectation that the patient is going to continue to decline is important. As the patient declines and intakes decline, the body is not able to mend itself and breakdown is more common. They may have skin breakdown that is directly related to their decline. Education should be provided to the patient and family regarding the function of the skin and the common issues seen with a decline in status. As well as the education being completed, the documentation of it needs to follow noting the education and the understanding of the education from the patient and family. (NPUAP).

Appropriate and thorough documentation should be a focus for every facility. It has saved many facilities from deficiencies and continues to be a deciding factor in the investigations of wounds. While the origin of the wound is important with regards to state surveys, etc., the most important issue is the patient. Too many times, the nursing staff will be expending such vital energy into proving a nosocomial wound is actually community, that they may miss the bigger picture, which is the overall care of the patient. From a patient's eyes, it does not matter where the wound originated. It matters to heal the wound.

Much is still be learned about how long it takes to develop wounds, and the future will hold more objective determinations in holding the appropriate facility responsible, whether it be the hospital, or the long term care facility. In the meantime, document thoroughly to protect your patient, to protect your facility, and to protect your license.

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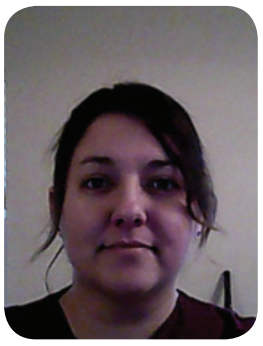

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is a Corporate Nurse for the Onix Group. These facilities provide short term rehabilitation and long term care for residents in Delaware. The Onix Group recently celebrated a grand opening of their newest facility, Silverside Nursing and Rehab, in Wilmington, Delaware. Catherine's current focus extends from Millsboro's Renaissance facility to Dover's Capitol Healthcare. She frequently educates through chart audits, providing the necessary educational leadership focusing on appropriate and thorough documentation. She is a computer expert, pushing our nurses into the future with electronic medical records. Prior to this position, Catherine enjoyed an educational leadership role with Broadmeadow Healthcare in Middletown, Delaware, There, she focused on quality nursing education, infection control, and was instrumental in bringing the coveted "Five Star" status to Onix facilities. Catherine is currently excelling in her Nurse Practitioner Program at Wilmington University for Adult/Geriatrics. She is happily married with four beautiful children. When Cat sums up her life, it is with five simple words that resonate with pride and accomplishment: "I love being a nurse."

Weighing In On The SCALE

Teresa Matthews, FNP-C, CWCN, RN

An expert panel was established to formulate a consensus statement on Skin Changes At Life's End (SCALE). The panel consists of 18 internationally recognized key opinion leaders including clinicians, caregivers, medical researchers, legal experts, academicians, a medical writer and leaders of professional organizations. These experts held an inaugural forum on April 4-6, 2008 in Chicago, IL. The panel discussed the nature of SCALE, including the proposed concepts of the Kennedy Terminal Ulcer (KTU) and skin failure along with other end of life skin changes. The final consensus document and statements were edited and reviewed by the panel after the meeting. The document and statements were initially externally reviewed by 49 international distinguished reviewers

The skin is the body's largest organ and like any other organ is subject to a loss of integrity. It has an increased risk for injury due to both internal and external insults. The panel concluded that: our current comprehension of skin changes that can occur at life's end is limited, and that contrary to popular myth, not all pressure ulcers are avoidable.

Specific areas requiring research and consensus include: 1) the identification of critical etiological and pathophysiological factors involved in SCALE, 2) clinical and diagnostic criteria for describing conditions identified with SCALE, and 3) recommendations for evidence-informed pathways of care.

The statements from this consensus document are designed to facilitate the implementation of knowledge-transfer-into-practice techniques for quality patient outcomes. This implementation process should include interprofessional teams (clinicians, lay people and policy makers) concerned with the care of individuals at life's end to adequately address the medical, social, legal, and financial ramifications of SCALE.

As a result of the 2-day panel discussion and subsequent panel revisions, and with input from a panel of noted wound care experts in a modified Delphi method approach, the following 10 statements are proposed by the SCALE Expert Panel: (Please note that these are the direct statements from the panel with modified comment following.)

* Statement 1. Physiologic changes that occur as a result of the dying process may affect the skin and soft tissues and may manifest as observable (objective) changes in skin color, turgor, or integrity, or as subjective symptoms such as localized pain. These changes can be unavoidable and may occur with the application of appropriate interventions that meet or exceed the standard of care.

When the dying process compromises the homeostatic mechanisms of the body, a number of vital organs may become compromised. The body may react by shunting blood away from the skin to these vital organs, resulting in decreased skin and soft-tissue perfusion and a reduction of the normal cutaneous metabolic processes. Minor insults can lead to major complications, such as skin hemorrhage, gangrene, infection, skin tears, and pressure ulcers that may be markers of SCALE. See statement 6 for further discussion.

* Statement 2. The plan of care and patient response should be clearly documented and reflected in the entire medical record. Charting by exception is an appropriate method of documentation.

The record should document the patient's clinical condition, including comorbidities, pressure ulcer risk factors, significant changes, and clinical interventions that are consistent with the patient's wishes and recognized guidelines for care. If your facility is using the Braden, this would be a perfect time to repeat the assessment. Facility policies and guidelines for record keeping should be followed, and facilities should update these policies and guidelines as appropriate. The impact of the interventions should be assessed and revised as appropriate. This documentation may take many forms. Specific approaches to documentation of care should be consistent with professional, legal, and regulatory guidelines and may involve narrative documentation, the use of flow sheets, or other documentation systems/tools. The current documentation that this writer is witnessing does not encompass end of life skin changes, and leaves the door open for litigation and state regulatory issues. (International Association for Hospice & Palliative Care. Assessment and research tools. 2009. http://www.hospicecare.com/resources/pain-research.htm.)

If a patient is to be treated as palliative, it should be stated in the medical record, ideally with a reference to a family/caregiver meeting and that consensus was reached. If specific palliative scales, such as the Palliative Performance Scale, or other palliative tools were used, they should be included in the medical record. Palliative care must be patient centered, with skin and wound care being only a part of the total plan of care. (Victoria Hospice Society. Palliative Performance Scale. Version 2 (PPSv2). http://palliative.info/resource_material/PPSv2.pdf.)

It isn't reasonable to expect that the medical record will be an all-inclusive account of the individual's care. Charting by exception is an appropriate method of documentation. This form of documentation should allow the recording of unusual findings and pertinent patient risk factors. Some methods of clinical documentation are antiquated in light of today's complexity of patient care and rapidly changing interprofessional healthcare environment; many current documentation systems need to be revised and streamlined. There is an abundance of "double-documenting" and repetitively repeating the same information in different areas of the chart. This creates a high risk for error.

* Statement 3. Patient-centered concerns should be addressed, including pain and activities of daily living.

A comprehensive, individualized plan of care should address not only the patient's skin changes and comorbidities, but also any patient concerns that impact quality of life, including psychological and emotional issues. Research suggests that, for wound patients, health-related quality of life is especially impacted by pain, change in body image, odors, and mobility issues. It isn't uncommon for these factors to have an effect on aspects of daily living, nutrition, mobility, psychological factors, sleep patterns, and socialization. Addressing these patient-centered concerns optimizes activities of daily living and enhances a patient's dignity. (Price, 2007).

* Statement 4. SCALE is a reflection of compromised skin (reduced soft-tissue perfusion, decreased tolerance to external insults, and impaired removal of metabolic wastes).

When a patient experiences SCALE, tolerance to external insults (such as pressure) decreases to such an extent that it may become clinically and logistically impossible to prevent skin breakdown and the possible invasion of the skin by microorganisms. Compromised immune response may also play an important role, especially in patients with advanced cancer and with the administration of corticosteroids and other immunosuppressant agents.

Skin changes may develop at life's end despite optimal care, as it may be impossible to protect the skin from environmental insults in its compromised state. These changes are often related to other cofactors, including aging, coexisting diseases, and drug adverse events. SCALE, by definition, occurs at life's end, but skin compromise may not be limited to end-of-life situations; it may also occur with acute or chronic illnesses, and in the context of multiple organ failure, it isn't limited to the end of life. However, these situations are beyond the scope of this panel's goals and objectives. (Langemo, 2006).

* Statement 5. Expectations around the patient's end-of-life goals and concerns should be communicated among the members of the interprofessional team and the patient's circle of care. The discussion should include the potential for SCALE, including other skin changes, skin breakdown, and Pressure Ulcers.

It's important that the provider(s) communicates and documents goals of care, interventions, and outcomes related to specific interventions (statement 2). The patient's circle of care includes the members of the patient unit, including family, significant others, caregivers, and other healthcare professionals who may be external to the current interprofessional team. Communication with the interprofessional team and the patient's circle of care should be

Continued on Page 11

The SCALE: Continued from Page 10

documented. The education plan should include realistic expectations surrounding end-of-life issues, with input from the patient if possible. Communication of what to expect during end of life is important, and this should include changes in skin integrity.

Being mindful of local protected health information disclosure regulations (such as the Health Insurance Portability and Accountability Act of 1996 [HIPAA]), the patient's circle of care needs to be aware that an individual at the end of life may develop skin breakdown, even when care is appropriate. They need to understand that skin function may be compromised to a point in which there's diminished reserve to tolerate even minimal pressure or external insult. Educating the patient's circle of care upfront may help reduce the chances of shock and emotional reactions if end-of-life skin conditions occur. This education includes information that mobility decreases as one nears the end of life. The individual frequently has a "position of comfort" that he or she may choose to maintain, resulting in a greater potential for skin breakdown. Some patients elect to continue to lie on the pressure ulcer, stating that it's the most comfortable position for them. Respecting the coherent patient's wishes is important.

With the recognition that these skin conditions are sometimes a normal part of the dying process, there's less potential for assigning blame and a greater understanding that skin organ compromise may be an unavoidable part of the dying process.

Discussions regarding specific trade-offs in skin care should be documented in the medical record. For example, patients may develop pressure ulcers when they can't be (or don't want to be) turned because of pain or the existence of other medical conditions. Pressure ulcers may also occur in states of critical hypoperfusion because of underlying physical factors, such as severe anemia, hypoxia, hypotension, peripheral arterial disease, or severe malnutrition. Care decisions must be made with the total goals of the patient in mind and may be dependent on the setting of care, trajectory of the illness, and priorities for the patient and family. Comfort may be the overriding and acceptable goal, even though it may be in conflict with best skin care practice. In summary, the patient and family should have a greater understanding that skin organ compromise may be an unavoidable part of the dying process.

* Statement 6. Risk factors, symptoms, and signs associated with SCALE haven't been fully elucidated, but may include:

—weakness and progressive limitation of mobility

—suboptimal nutrition, including loss of appetite, weight loss, cachexia and wasting, low serum albumin/prealbumin level, and low hemoglobin, as well as dehydration

—diminished tissue perfusion, impaired skin oxygenation, decreased local skin temperature, mottled discoloration, and skin necrosis

—loss of skin integrity from any of a number of factors, including equipment or devices, incontinence, chemical irritants, chronic exposure to body fluids, skin tears, pressure, shear, friction, and infections

—impaired immune function.

Diminished tissue perfusion is the most significant risk factor for SCALE and generally occurs in areas of the body with end arteries, such as the fingers, toes, ears, and nose. These areas may exhibit early signs of vascular compromise (such as dusky erythema, mottled discoloration, local cooling, and, eventually, infarcts and gangrene) and ultimately collapse.

As the body faces a critical illness or disease state, a normal protective function may be to shunt a larger percentage of cardiac output from the skin to more vital internal organs, thus averting immediate death. Chronic shunting of blood to the vital organs may also occur as a result of limited fluid intake over a long period. Most of the skin has collateral vascular supply, but distal locations, such as the fingers, toes, ears, and nose, have a single vascular route and are more susceptible to a critical decrease in tissue oxygenation because of vasoconstriction. Furthermore, the ability to tolerate pressure is limited in poorly perfused body areas.

Additional literature reviews and clinical research are needed to more thoroughly comprehend and document all of the potential risk factors associated with SCALE and their clinical manifestations.

* Statement 7. A total skin assessment should be performed regularly and all areas of concern documented consistent with the wishes and condition of the patient. Pay special attention to bony prominences and skin areas with underlying cartilage. Areas of special concern include the sacrum, coccyx, ischial tuberosities, trochanters, scapulae, occiput, heels, digits, nose, and ears. Describe the skin or wound abnormality exactly as assessed.

It's important to assess the whole body because there may be signs that relate to skin compromise.

* Statement 8. Consultation with a qualified healthcare professional is recommended for any skin changes associated with increased pain, signs of infection, skin breakdown (when the goal may be healing), and whenever the patient's circle of care expresses a significant concern. There are very definite descriptive terms for skin changes that can be used to facilitate communication between healthcare professionals (statement 7). Until more is known about SCALE, subjective symptoms need to be reported and objective skin changes described. This will allow for identification and characterization of potential end-of-life skin changes.

An accurate diagnosis can lead to decisions about the area of concern and whether it's related to end-of-life care and/or other factors. The diagnosis will help determine appropriate treatment and establish realistic outcomes for skin changes. For pressure ulcers, it's important to determine whether the ulcer may be (1) healable within an individual's life expectancy, (2) maintained, or (3) nonhealable or palliative. The treatment plan will depend on an accurate diagnosis, the individual's life expectancy and wishes, family members' expectations, institutional policies, and the availability of an interprofessional team to optimize care. Remember that patient status can change and appropriate reassessments with determination of likely outcomes may be necessary.

It's important to remember that a maintenance or nonhealable wound classification doesn't necessarily equate with withholding treatment. For example, the patient may benefit with improved quality of life from surgical debridement and/or the use of advanced support surfaces. (Krasner, 2007).

* Statement 9. The probable skin change etiology and goals of care should be determined. Consider the 5 Ps for determining appropriate intervention strategies:

—prevention

—prescription (may heal with appropriate treatment)

—preservation (maintenance without deterioration)

—palliation (provide comfort and care)

—preference (patient desires).

Prevention is important for well-being, enhanced quality of life, and potential reimbursement and to avoid unplanned medical consequences for end-of-life care. The skin becomes fragile when stressed with decreased oxygen availability associated with the end of life. The plan of care needs to address excessive pressure, friction, shear, moisture, suboptimal nutrition, and immobilization.

Prescription refers to the interventions for a treatable lesion. Even with the stress of dying, some lesions are healable after appropriate treatment. Interventions must be aimed at treating the cause and at patient-centered concerns (pain, quality of life) before addressing the components of local wound care as consistent with the patient's goals and wishes.

Preservation refers to situations in which the opportunity for wound healing or improvement is limited, so maintenance of the wound in its present clinical state is the desired outcome. A maintenance wound may have the potential to heal, but there may be other overriding medical factors that could direct the interprofessional team to maintain the status quo. For example, there may be limited access to care or the patient may simply refuse treatment.

Palliation refers to those situations in which the goal of treatment is comfort and care, not healing. A palliative or nonhealable wound may deteriorate because of a general decline in the health of the patient as part of the dying process or because of hypoperfusion associated with noncorrectable critical ischemia. In some situations, palliative wounds may also benefit from some treatment interventions such as surgical debridement or support surfaces, even when the goal isn't to heal the wound.

Preference includes taking into account the preferences of the patient and the patient's circle of care.

Continued on Page 10

The SCALE: Continued from Page 11

The 5 Ps enabler can be used in combination with the SOAPIE (Subjective, Objective, Assessment, Plan, Implement, Evaluate/Educate) mnemonic to help explain the process of translating this recommendation into practice. Realistic outcomes can be derived from appropriate SOAPIE processes, with the 5 Ps becoming the guide to the realistic outcomes for each individual. (Sibbald, 2007).

The SCALE is a vital tool to enable all of us to determine a plan of care consistent with the patient's needs. There is a lot of subjectivity is determining when death may occur. I believe that is the way it is supposed to be. However, if we have objective indicators that death is imminent, our strategic interventions become focused on comfort. After all, isn't that why we all became nurses?

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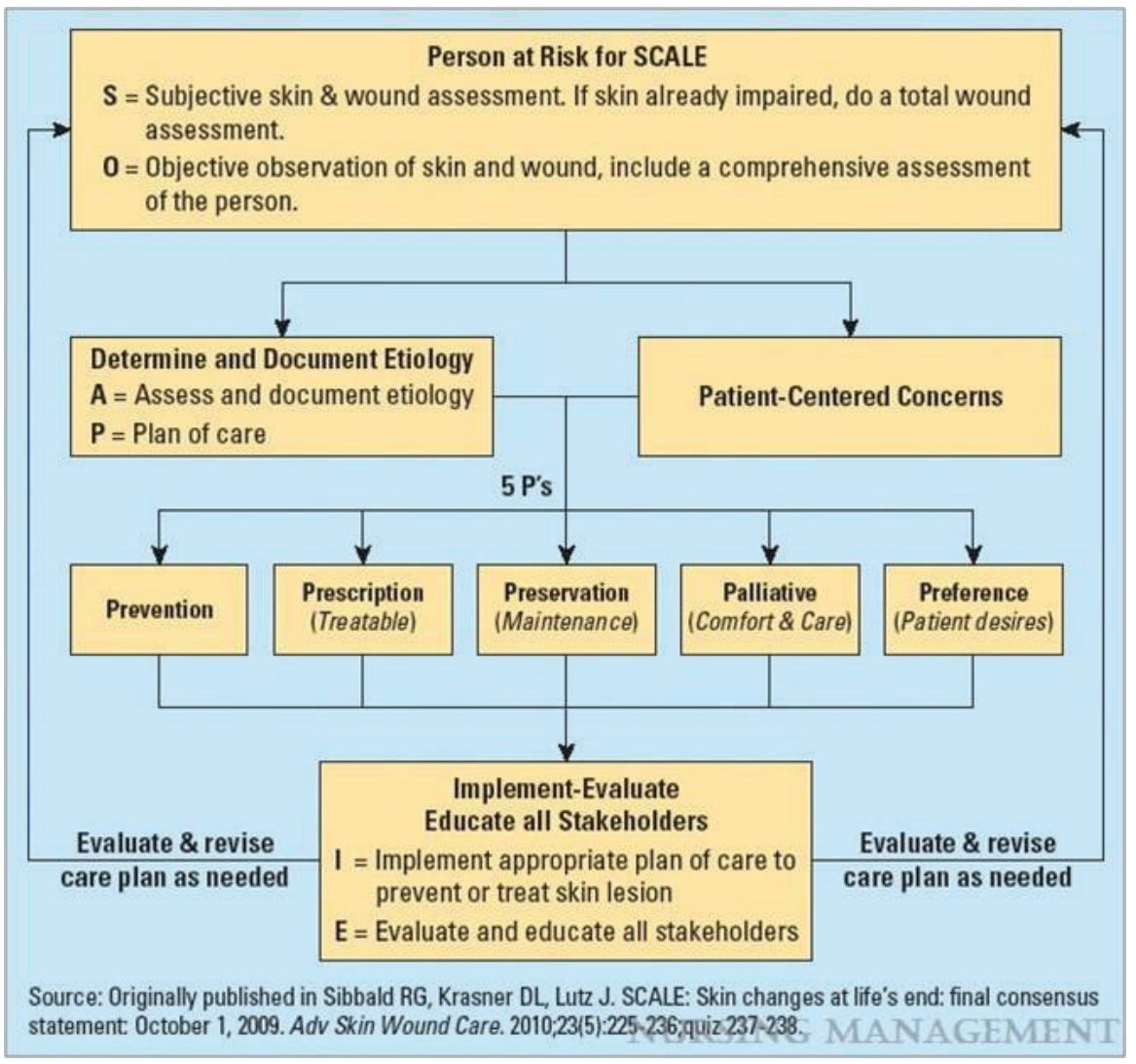

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AND THE SURVEY SAYS….

The regulatory issues with "Avoidable" vs. "Unavoidable" pressure ulcers are dynamic and individually focused. It is important, as a team, to provide justification for the unavoidable development or deterioration of a pressure ulcer. This will involve the Medical Director to write a detailed assessment, as well as a note from the wound specialist, physical therapy (if appropriate), and the nutritionist. The most important documentation will be from the nursing staff. Was the preventive care:

- aggressive,
- consistent,
- appropriate
- resident specific?

If not, the pressure ulcer may have been "avoidable." The presence of any one, or of many, risk factors does not make a pressure ulcer "avoidable!"

KENNEDY TERMINAL ULCERS FAQs

1. What is a Kennedy Terminal Ulcer?

A Kennedy Terminal Ulcer is a pressure ulcer some people develop as they are dying.

2. What does a Kennedy Terminal Ulcer look lik Kennedy Terminal Ulcers FAQs e?

It usually presents on the sacrum. It can be shaped like a pear, butterfly or horseshoe. It can have the colors of red, yellow, black or purple. The borders of the ulcer are usually irregular. It has a sudden onset. The two statements you hear most are: 1: “Oh, my gosh, that was not there at 7 am!.” 2: “I worked Friday, it was not there then, I was off the weekend and when I came back on Monday there it was.”

3. How does a Kennedy Terminal Ulcer progress?

It usually starts out as a blister or a Stage II and can rapidly progresses to a Stage III or a Stage IV. In the beginning it can look much like an abrasion as if someone took the patient and drug his or her bottom along a black top driveway. It can become deeper and starts to turn colors. The colors can start out as a red/purple area then turn to yellow and then black.

4. How are these different than other pressure ulcers?

They can start out larger than other pressure ulcers, are usually more superficial initially and develop rapidly in size, and depth and color.

5. What kind of treatment is best for a Kennedy Terminal Ulcer?

Treatment for a Kennedy Terminal Ulcer is the same as for any other pressure ulcer with the same characteristics. What you see is what you treat. Assess this and treat it as though it were any other wound. When it is in the blanchable/or non-blanchable intact skin stage the goal would be to relieve the pressure and protect the area. When it becomes a Stage II or a partial thickness ulcer usually there is not a lot of drainage and a foam dressing is indicated. When it is a full thickness wound, Stage III or IV depending on the amount of drainage you could use a calcium alginate with a foam. If there is necrotic tissue slough (yellow tissue) or eschar (black, brown, beige or tan tissue) you may want to use an enzymatic debriding agent. If it becomes clinically infected you may want to consider a dressing with silver. Due to the fact that such ulcers occur in the terminally ill, the comfort of the person is of the utmost importance in deciding on the course of treatment. Therefore, except in rare circumstances, sharp debridement would not be an indication. What are those rare circumstances? Loose, stringy, mal-odorous slough that would be easy to trim with minimal discomfort.

6. What causes a Kennedy Terminal Ulcer?

Further research needs to be done on this subject. However, one idea is it may be a blood perfusion problem exacerbated by the dying process. The skin is an organ, just like the heart, lungs, kidneys, lungs and liver. It is the largest of the body organs and is the only one that is on the outside of the body. It can reflect what is going on inside the human body. One theory is as people are approaching the dying process the internal organs begin to slow down and go into what is thought of as multi-organ failure. This is where all the organs start to slow down and not function as efficiently as previously. Skin failure can occur just as any other organ can fail in this process. No particular symptomatology may be detected except the skin over bony prominences starts to show effect of pressure in a shorter time frame

7. Can a Kennedy Terminal Ulcer get better?

Yes, and no.

The majority of them do not. It is something that is generally thought to be terminal. However, it has been known for a patient that was terminal or at the end of life and the patient or family decided they did want intravenous or tube feeding intervention along with other appropriate modalities to change their mind and decide they did want all available interventions. At that point I have known of patients to have this phenomena reversed, but it is rare. I feel some patients are not ready to die, and I have seen the reversal. Should a patient survive a Kennedy Terminal Ulcer, they will remain at the highest risk for breakdown, and full interventions will need to remain.

8. When was a Kennedy Terminal Ulcer first described?

In March of 1989 the National Pressure Ulcer Advisory Panel put together their first conference in Washington D.C. The conference was to help determine how many pressure ulcers there were (prevalence) and could you predict who was going to get them.

9. Why is it important to know this?

If a patient is receiving full rehabilitation therapy, out-patient appointments and schedule procedures, it may be time to consider an alternative plan of care. Palliative care at end of life would be welcomed by a patient, as well as their families. Having an objective diagnostic presentation may help the families accept the end of life, and it may encourage distant family members to come to the bedside. Accurately diagnosing a Kennedy Ulcer is a rare gift, not often seen in healthcare. This sign will help in the dying process in immeasurable ways.

10. How did it get its name?

It was named by the Medical Director of the Byron Health Center is Fort Wayne, Indiana, Dr. Stephen Glassley. He termed it “The Kennedy Terminal Ulcer”. H named it after the first Family Nurse Practitioner, in Fort Wayne, Indiana, Karen Lou Kennedy. Record keeping was initiated indicating some patients developed pressure ulcers with similar characteristics that went on to die in a short time frame. As the data was reviewed a pattern developed as to the characteristic and time frame from onset to death. This data was reviewed by the medical director, thus naming it the “Kennedy Terminal Ulcer”.

11. Why have I not heard of this before?

In about 2002 Dr. Jeffrey M. Levine, MD, AGSF, found a long lost textbook published in 1877 by professor Dr. Jean-Martin Charcot called Lectures the Diseases of The Nervous System. Dr. Charcot was a French neurologist considered the father of modern neurology and the first professor of diseases of the nervous system regarded as one of the most important researchers in the field of clinical neurology of the 19th century. This ulcer, not named as such yet, was described here. I am bringing it to the forefront of my own private practice to help these patients, to help the families, and to help the facilities. Nurses take it hard when a new wound is found on a patient. Removing this guilt will allow more energy for healing, prevent unnecessary state citations and tags, and allow us to do more of what we do best as nurses….care.

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