Enhancing end-of-life skin care to prevent pressure ulcers in primary care

Ray Samuriwo

Good primary care improves the health and wealth of nations, as it is the context in which the majority of health care is delivered. Improving the quality of palliative care and reducing adverse patient-related events are priority areas for improvement in primary care. One aspect that community nurses can improve is the quality of end-of-life skin care. Given that the main objective of all end-of-life care is to facilitate a comfortable and dignified death for the patient in line with their wishes, it is important for nurses in primary care to be aware of what they can do to ensure the consistent delivery of safe end-of-life skin care. This paper highlights key elements of end-of-life skin care that should be considered by community nurses in their efforts to improve the prevention of pressure ulcers in primary care.

KEYWORDS:
- Primary care
- End of life care
- Pressure ulcers
- Community nurses
- Quality Improvement

There is a global focus on ensuring universal access to high-quality health care that is delivered in a fair, just and equitable manner, and which improves population health and underpins the sustainable development of nations (World Health Organization [WHO] et al., 2018). The recent Astana declaration (WHO and UNICEF, 2018; www.who.int/primary-health/conference-phc/declaration; www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf) reiterated the international focus on improving the quality and safety of primary care, as it is an integral part of healthcare systems which enhances the health and wealth of nations.

Focus on improving the safety and quality of primary care is apt: the majority of health care is delivered in this context, and most people’s first contact with their healthcare system is via primary care (WHO, 2012; Cresswell et al., 2013). Therefore, primary care professionals play a key role in ensuring the consistent delivery of safe, high-quality, patient-centred care, and coordinating specialist care in line with patients’ needs (WHO, 2012; Cresswell et al., 2013; Organisation for Economic Co-operation and Development [OECD], 2017).

Improving palliative care and reducing adverse healthcare-related events are two key international priorities for improving the quality and safety of primary care (OECD, 2017; WHO et al., 2018; WHO and UNICEF, 2018). Patient-centred palliation is recognised as central to the delivery of high-quality primary care in all contexts in effective healthcare systems (WHO et al., 2018; WHO and UNICEF, 2018).

The prevention of pressure ulcers is also a key global care quality indicator that is the focus of considerable quality improvements in primary care. This is because pressure ulcers are a largely avoidable, financially burdensome, adverse healthcare-related event that results in increased patient morbidity and mortality (National Pressure Ulcer Advisory Panel [NPUAP] et al., 2014; Slawomirski et al., 2017).

Pressure ulcers are the most common wounds that develop in patients who are receiving palliative care (Sibbald et al., 2010; Maida, 2013). When patients are approaching the end of life, their risk of developing such wounds increases due to physiological factors related to their disease progression and/or treatment (Sibbald et al., 2010; Maida, 2013). End-of-life skin care improvement efforts are challenging, as it can be difficult to determine which pressure ulcers can be prevented and which are unavoidable (Sibbald et al., 2010; Beldon, 2011; Maida, 2013).

Achieving the goal of consistently delivering high-quality care, which ensures patient safety, requires healthcare professionals and organisations to focus on the consistent delivery of care in an equitable and just manner. Due consideration of the preferences of the patient and their loved ones should also be taken into account at an organisational level (European Patients Forum [EPF], 2017). Nurses have been shown to play a key...
role in the delivery of safe, high-quality health care in a variety of contexts (Kirwan et al, 2013; Aiken et al, 2014). In most care settings, patient care is coordinated and overseen by a nurse throughout the care trajectory (Allen, 2018). Consequently, it is important for primary care nurses to be aware of how they can consistently deliver the best possible end-of-life skin care to maintain patients’ skin integrity for as long as possible.

A wide range of evidence focuses on key elements of end-of-life skin and wound care in secondary care settings (Sibbald et al, 2010; Beldon, 2011; Maida, 2013). However, primary care is distinct from other elements of the healthcare system in a variety of ways, such as the length of care episodes, infrastructure and the level of patient engagement (Makeham et al, 2015). These differences merit consideration in relation to quality improvement efforts.

People working in all healthcare systems, irrespective of context, should consider how they can use the best available evidence and share learning to improve quality of patient care (WHO et al, 2018). Detailed step-by-step guidance on the delivery of end-of-life skin care to dying patients, and the strength of evidence underpinning each element of care, is set out in international guidelines (Sibbald et al, 2010; NPUAP et al, 2014) and other key documents on pressure ulcer prevention (Maida, 2013; Langemo et al, 2015).

This paper utilises a range of evidence to highlight the key elements of end-of-life skin care that can be used to prevent pressure ulcers. These elements can be integrated into improvement initiatives by nurses in primary care.

DECISION-MAKING AND TERMINOLOGY

Nurses can find it challenging to make decisions about the delivery of skin care to prevent pressure ulcers in patients who are dying (Samuriwo and Dowding, 2014). This is because of changes that occur to the body as part of the dying process (White, 2017). As people approach the end of life, they are more susceptible to greater exposure to factors that contribute to pressure ulcers, such as diminished skin perfusion, limited mobility, incontinence, and decreased nutrition (Sibbald et al, 2010; Langemo et al, 2015; White, 2017; Hotaling and Black, 2018).

When making decisions about skin care at the end of life, nurses should consider a variety of factors, such as pathophysiological changes to the patient’s body as part of the dying process, how close the patient is to the end of life, how comfortable the patient is, and the wishes of the patient and their family (Samuriwo and Dowding, 2014; Langemo et al, 2015).

The complex interaction of these different factors often results in variations in the intensity and quality of skin care that is delivered to the same patient by different nurses (Samuriwo and Dowding, 2014). Therefore, any efforts to improve end-of-life skin care in primary care must make it as easy as possible for community nurses to make the most appropriate decisions in line with the patient’s preferences. This helps to minimise unwarranted variations in the quality of care that the patient receives. In the author’s clinical opinion, one improvement approach that could be used to make decision-making easier would be to develop an end-of-life skin care decision-making aid, or care pathway that can be used by nurses in primary care.

It is also important for nurses in primary care to be aware of some of the main viewpoints and terms that are used with regards to pressure ulcers that develop at the end of life. There are two main views relating to pressure ulcers that develop as a result of the dying process, how close the patient is to the end of life, how comfortable the patient is, and the wishes of the patient and their family (Samuriwo and Dowding, 2014; Langemo et al, 2015).

When making decisions about skin care at the end of life, nurses should consider a variety of factors, such as pathophysiological changes to the patient’s body as part of the dying process, how close the patient is to the end of life, how comfortable the patient is, and the wishes of the patient and their family (Samuriwo and Dowding, 2014; Langemo et al, 2015).

The terms KTU, TB-TTI and skin failure and Skin Changes at Life’s End (SCALE) (Langemo and Brown, 2006; Beldon, 2011; Ayello, 2016, Hotaling and Black, 2018). The terms KTU, TB-TTI and skin failure tend to be used by people who perceive pressure ulcers at the end of life to be unavoidable. The view of most people who refer to pressure ulcers in this way is that these types of wounds are a sign that the patient’s death is imminent.

However, there has been a move away from using different terms for pressure ulcers that develop as a person approaches the end of life in some settings. The use of different terms, and the debate about whether pressure ulcers can be prevented when a person is dying, can divert attention from where it should be — on the delivery or safe, high-quality patient-centred end-of-life skin care.

Guidance from the NHS in England (NHS Improvement, 2018) has abolished the use of terms such as KTU, and clinicians...
are now compelled to use the term pressure ulcer when skin disintegration occurs in a person that is approaching the end of life.

The rationale for this decision was to ensure that pressure ulcers that develop in patients at the end of life are treated and classified in the same way as pressure ulcers in other patients (NHS Improvement, 2018). This clarification of the terminology used in England highlights that nurses should focus on doing all they can to ensure that patients at the end of life are consistently given the best possible skin care. This should be irrespective of the view that is adopted about pressure ulcers at the end of life, or the terminology used.

**ASSessment AND EVALuATION**

The first key element of patient assessment in end-of-life skin care is to establish the patient's prognosis, and if they are dying, to deliver individualised patient-centred care (Sibbald et al, 2010; Langemo et al, 2015; Hotaling and Black, 2018). Once it has been established that the patient is dying, it is important to find out what the end-of-life care wishes, preferences and goals are for the patient and their family (NPUAP et al, 2014; Hotaling and Black, 2018).

This is vital, as the main focus of any aspect of care at the end of life should be to deliver it in a manner that respects the wishes of the patient and their family, in order to bring about what they consider to be a comfortable, dignified, ‘good’ death (Bergman et al, 2011; Hotaling and Black, 2018).

Establishing the patient and family's priorities for end-of-life care is also important because they may opt not to receive some aspects of skin care for personal, spiritual or religious reasons (Langemo and Brown, 2006; White, 2017; Hotaling and Black, 2018). When patients and their families decline some aspect of end-of-life skin care, they should be informed of the possible consequences and advised to consider alternative approaches to protect the skin that may be less effective (NPUAP et al, 2014; Hotaling and Black, 2018). For example, if a patient refuses to be repositioned, they can be offered a more advanced support surface and/or prophylactic dressings to protect their skin at the end of life.

As with any other aspect of health care, it is important to carry out a holistic assessment of the patient and their needs, which, for patients who are approaching the end of life, includes a formal pressure ulcer risk as well as pain assessment (Burt, 2013; NPUAP et al, 2014; Langemo et al, 2015).

Undertaking pressure ulcer risk and pain assessment simultaneously will ensure that any care delivered to protect the skin does not cause pain or result in distress for the patient (Burt, 2013; Langemo et al, 2015).

This formal pressure ulcer risk assessment must be revisited and updated when the patient’s condition changes (Burt, 2013). It should include comprehensive inspection of the patient's skin and use of a validated pressure ulcer risk assessment tool, which takes into account key risk factors such as continence, mobility, nutritional status and level of consciousness (Langemo et al, 2015). However, every nurse should also use their own clinical judgement to make a decision about how best to deliver skin care to protect the patient's skin. As said, patients should be reassessed, and any skin care that has been delivered should be evaluated regularly as the patient's condition changes.

**CARE PLANNING AND DELIVERY**

Patients who are approaching the end of life must be placed on appropriate support surfaces and positioned in such a way that minimises their exposure to shear, friction and pressure, all of which result in skin breakdown (Burt, 2013). Selection of support surface and the patient's repositioning schedule should be informed by the patient’s condition as well their wishes and preferences (NPUAP et al, 2014). If necessary, community nurses should seek further advice and guidance from colleagues with expertise in tissue viability or palliative care on what support-specific measures they can use to protect the needs of patients in their care.

Other measures that can be used to protect the skin at the end of life include using prophylactic dressings on parts of the body that are at high risk of pressure ulcer formation. Catheters and faecal management systems can also be used for patients with continence issues (Hotaling and Black, 2018).

When making decisions about the frequency of patient repositioning, nurses should decide on the best course of action to maintain the patient's skin integrity or to prevent further skin disintegration, and consider the preferences of the patient and their family (Hotaling and Black, 2018). It is also important that patients who are approaching the end of life are given analgesia before repositioning if they are in pain or distress from their underlying condition (Langemo et al, 2015).

One way to ensure that all patients at the end of life receive consistent high-quality care is to adopt a hazard-reduction strategy, where focus is on the comfort of the patient as well as minimising their exposure to pressure ulcer risk factors. A hazard-reduction strategy employs approaches to maintaining skin integrity that are known to be highly effective, such as regular patient repositioning (Samuriwo and Dowding, 2014). As said, the frequency and intensity of patient repositioning should also evolve in line with the patient's condition and be informed by their preferences.
Therefore, it would be best for community nurses to try to regularly reposition patients who are approaching the end of life, alongside other aspects of palliative care. However, it is not appropriate to reposition the patient when it is contraindicated by the patient’s underlying condition, it is apparent that their death is imminent, or there is a specific directive from the patient or their family opting out of regular repositioning.

It is also important to explain to patients, family members and carers what they can do to protect the skin, as patients are keen to learn about what they can do to maintain their skin integrity and to treat pressure ulcers (Chaboyer et al, 2017). Some family members and carers may also want to actively participate in the delivery of end-of-life skin care of their loved ones. Providing patients and family members with knowledge and insight into key elements of care may also bring about patient and family activation. This helps to reduce adverse patient safety events, because patients and their families have the knowledge, confidence and attributes that they need to manage key elements of their care (Coulter and Ellins, 2006).

Information about key elements of end-of-life skin care can be provided to patients and their families through online resources and information booklets that use easy to understand everyday language. Such resources have been shown to be effective in informing patients and their families about other aspects of pressure ulcer prevention (Gethin and McIntosh, 2014).

It should also be remembered that in some primary care settings, community nurses and carers in the community may not be able to reposition the patient outside of office hours, such as overnight, on weekends or bank holidays. Therefore, well-informed family members and carers may be able to do so, which helps to maintain skin integrity. However, if family members wish to be involved in the delivery of end-of-life skin care, they should be educated about some of the possible outcomes. For example, they should be informed that the patient could die as they are being turned, or not long afterwards.

If family members wish to reposition the patient without community nurses, there needs to be a mechanism in place to ensure that the patient has received sufficient analgesia. There should also be the opportunity for family members and carers to seek further guidance from a community nurse at any time of day if they have any concerns about the patient’s skin or overall condition. It is also important that family members are aware that even if the patient receives the best possible care, they can still develop pressure ulcers at the end of life, as they cannot always be prevented (Langemo and Brown, 2006; Sibbald et al, 2010; Langemo et al, 2015; Hotaling and Black, 2018).

CONCLUSION

Nurses in primary care have an obligation to improve the quality and safety of the care that they deliver, and to ensure that end-of-life skin care to prevent pressure ulcers is delivered in a fair, just and equitable manner.

This paper has drawn upon global evidence relating to primary care, palliative care, tissue viability and nursing to highlight the elements of end-of-life skin care that can be integrated into improvement initiatives to maintain skin integrity. It is hoped that the information and tips set out in this paper will be of interest to healthcare professionals with an interest in improving the quality of skin care that they deliver to patients at the end of life. The insights shared in this paper will also enable primary care nurses to better understand what they can do to improve the quality of end-of-life skin care while considering some of the challenges that they may encounter.

It is important that patients and families are informed of the possible consequences of declining end-of-life skin care, and that they are advised to consider alternative approaches to protect the skin.

REFERENCES

Beldon P (2011) Skin changes at life’s end: SCALE ulcer or pressure ulcer? Br J Community Nurs 16(10): 491–4
END-OF-LIFE CARE

KEY POINTS

- The risks of developing wounds such as pressure ulcers are increased for patients approaching the end of life.

- Nurses making decisions about end-of-life skin care have to take a variety of factors into account, including pathophysiological changes to the body.

- Recent guidance advises that pressure ulcers that develop in patients at the end of life are treated and classified in the same way as pressure ulcers in other patients.

- As with any other aspect of health care, a holistic assessment of the patient and their needs should be carried out.

- Nurses in primary care have an obligation to ensure that end-of-life skin care to prevent pressure ulcers is delivered in a fair, just and equitable manner.


---

Revalidation Alert

Having read this article, reflect on:

- How you would implement initiatives to improve decision-making around end-of-life skin care
- The information you would give patients and their families on protecting the skin
- Why patients approaching the end of life are at risk of developing pressure ulcers
- How to avoid unwarranted variations in care.

Then, upload the article to the free JCN revalidation e-portfolio as evidence of your continued learning: www.jcn.co.uk/revalidation