

Skin Changes At Life's End

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In April of 2008, wound care experts met for a round table discussion of the occurrence of Skin Changes At Life's End (SCALE). The condition of a patient's skin can provide a great deal of insight into his/her internal health. Illnesses that usually worsen and result in death are frequently accompanied by pressure ulcers. SCALE, therefore, is a term for the compromise of the skin organ during the end stages of life.

As a result of their discussion of this phenomenon, and subsequent input from experts in wound care and palliative medicine, on October 1, 2009 the SCALE Expert Panel published the following ten consensus statements:

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.

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.

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

Statement 4: Skin changes at life's end are a reflection of compromised skin (reduced soft tissue perfusion, decreased tolerance to external insults, and impaired removal of metabolic wastes).

Statement 5: Expectations regarding 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.

Statement 6: Risk factors, symptoms and signs associated with SCALE have not 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/pre-albumin, 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.

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Statement 7: A total skin assessment should be performed regularly and document all areas of concern consistent with the wished 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.

Statement 8: Consultation with a qualified health care 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.

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

- Prevention
- Prescription (may heal with appropriate treatment)
- Preservation (maintenance without deterioration)
- Palliation (provide comfort and care)
- Preference (patient desires)

Statement 10: Patients and concerned individuals should be educated regarding SCALE and the plan of care.

Providers should take special note of Statements 2 and 7 of the Panel's recommendations regarding documentation, which, as always, is a crucial element of the provision of quality care. Statement 9 regarding education of patients and those involved in the care of patients about the development of pressure ulcers at the end of life is also a crucial point. In the absence of such documentation, it is often difficult for patients and others to understand why patients developed wounds, unless the care provided was substandard; a potential risk management issue. Education about types of changes in patients' skin at the end of life can be a very effective risk management tool.

Knowledge about wound care continues to advance. Providers must stay up to date on the latest developments.

Source:

https://www.gaymar.com/wcsstore/ExtendedSitesCatalogAssetStore/PDF/SCALE_Final_Draft_2009-10-05_HQP.pdf

(To obtain a copy of a book entitled *Wound Care: Legal Issues*, send a check for \$35.00 that includes shipping and handling made out to Elizabeth E. Hogue, Esq. to: Fulfillment, 107 Guilford, Summerville, SC 29483.)

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