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are modifiable and nonmodifiable risk factors that impact wound healing. In addition, CMS recognizes pressure injuries that may occur at the end of life and the characteristics surrounding the Kennedy terminal ulcer.

Interestingly, the International Classification of Diseases (ICD-10) does not currently provide any codes to support accurate coding of end-of-life wounds or any COVID-19 skin manifestations, so it is vital that wound documentation correctly describes skin manifestation etiologies. Wound documentation should also identify a wound prognosis (healable versus maintenance versus palliative) and then discuss the evidence to support this prognosis. For example, the phrase "delayed wound healing is expected due to" would be followed by a succinct but clear explanation of the factors impeding normal wound healing to establish realistic expectations for maintenance and palliative care wounds.

For example, if managing a wound in a diabetic patient with uncontrolled blood sugars and underlying vascular disease, it would be reasonable to document "delayed wound healing expected due to poor perfusion and uncontrolled diabetes." This patient's maintenance wound may eventually close if blood sugars are regulated and perfusion is restored (if a candidate). Importantly, the clinician needs to document which standards of wound care are being followed to justify that a stalled or declining wound is not due to a lack of appropriate care.

When the primary focus for a wound is no longer wound closure, the documentation should still reflect what can be done for the wound (see the table). It is inappropriate to declare any palliative wound untreatable and not continue to apply wound care standards simply because wound closure is unlikely.

Treatment Goals

Measurable wound goals can and should be identified. For example, a malodorous wound treated with a palliative care prognosis could have a goal focused on minimizing the smell so the family can tolerate being at the bedside. Dressing selection, perhaps with charcoal, would align with this goal, and the measurable outcome would be diminished odor reported by the family.

In a world where older adults with chronic illness are living longer, successful wound management is not always defined by wound closure. Many maintenance wounds and even some palliative wounds do eventually heal. The goal for maintenance and palliative wound care, like any other condition, is to develop realistic plans of care and then take that next step to educate the patient and caregivers so everyone has the same expectations.

Dr. Nalls is the director of education for Capital Caring Health (CCH), where she collaborates with all CCH service lines to meet their educational needs as well as provides wound care consults to CCH patients in their home environment. She serves on the board of directors for the Association for the Advancement of Wound Care. She may be reached at vnalls@capitalcaring.org

Editor's Comment

Dr. Nalls's column on palliative wound care in the post-acute and long-term care setting reminds us of the importance of goals of care and symptom management when addressing maintenance wound care. As practitioners, we strive to cure what we can and close wounds. However, we need to recognize that delayed wound healing is common among older adults in PALTC settings. Preventing complications and effectively managing symptoms such as discomfort and drainage, as well as minimizing secondary infection are also worthy goals. We encourage you to share Dr. Nalls's suggestions for documentation of wound prognosis and links to practical resources with your wound care team.

— Elizabeth Galik, PhD, CRNP, editor in chief