Wound care expert Dr. Diane Krasner shares her experiences as co-chair of the SCALE Panel and corresponding author of the SCALE Final Consensus Statement.

Skin Changes At Life's End

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Sue MacInnes, RD, LD

Healthy Skin Editor Sue MacInnes interviews SCALE Panel Co-Chair Diane Krasner

Sue MacInnes:
What is the SCALE Panel and why was it formed?

Diane Krasner:
The SCALE Panel was convened to explore the issues surrounding skin conditions associated with dying patients. The panel reviewed existing literature, best practices and research on the issue. Eighteen participants met for the first panel meeting April 4-6, 2008 in Chicago, which was funded by an unrestricted educational grant from Gaymar Industries, Inc. Participants included nurses, physicians, legal experts and a medical writer. All had an interest in or clinical experience with skin conditions in dying patients. Included in the panel were Karen Lou Kennedy, a nurse practitioner who has published on the Kennedy Terminal Ulcer (www.kennedyterminalulcer.com) and Dr. Diane Langemo, who proposed the concept of skin failure. SCALE Panel members represented the continuum of care from acute care to hospice. Dr. Gary Sibbald and I served as panel co-chairs. Cindy Sylvia was the panel facilitator. Jim Lutz served as the medical writer. Dr. Thomas Stewart conceived the acronym SCALE: Skin Changes At Life's End.

Sue MacInnes:
What process did the SCALE Panel use to reach consensus?

Diane Krasner:
After reviewing the existing literature on the topic and hearing presentations by selected panel members, the SCALE panel worked in three teams, drafting preliminary consensus statements. Jim Lutz used audiotapes and notes from the April 2008 meeting to craft a Preliminary Consensus Statement. This document was reviewed and edited by the entire panel. From September 2008 to June 2009 the Preliminary Consensus Statement was presented internationally at wound conferences, published and posted on the SCALE website. Stakeholders were encouraged to circulate the document for comments. All the comments were used to generate a Final Consensus Statement, which was then returned to the original 18-member expert panel and a 52-member reviewer panel. The two groups of panel members then voted on each of the 10 statements for consensus using a modified Delphi Method approach. A quorum of 80 percent that strongly agreed or

somewhat agreed with each statement was used as a pre-determined threshold for having achieved consensus on each of the statements. A consensus based on 52 votes was reached after the first round of the Delphi. Numerous comments were made, and a final draft was written to incorporate the comments. The SCALE Final Consensus Statement was released on October 1, 2009.

Sue MacInnes:
How would you describe the SCALE Final Consensus Statement?

Diane Krasner:
The SCALE Final Consensus Statement reflects the current evidence and best practices surrounding Skin Changes At Life's End. The ten statements represent the expert opinions of thought leaders from around the world. There is clear agreement that more research needs to be undertaken to enhance our understanding of the multiple and complex skin change phenomena that occur during the dying process. In the meantime, the 10 consensus statements give practical and focused suggestions for clinical management. In addition to the 10 consensus statements, which are reprinted in this issue of *Healthy Skin*, the SCALE Final Consensus Statement includes a glossary, a reference list and several charts/enablers for clinical practice.

Sue MacInnes:
How can the SCALE documents be accessed and utilized?

Diane Krasner:
Free downloads of the SCALE documents are available at the website of the panel sponsor, Gaymar Industries: www.gaymar.com. Look under "Clinical Support and Education" and "SCALE Consensus Documents." In addition to the 19-page final consensus statement, there is a three-page guide and the SCALE annotated bibliography. All of these documents can be utilized for education and training. The SCALE documents have relevance across the continuum of care for all members of the interprofessional wound care team. For further information, contact corresponding author Dr. Diane Krasner at dlkrasner@aol.com.

Dr. Krasner is a Wound & Skin Care Consultant in York, PA. She works part-time at Rest-Haven York, is the lead co-editor of *Chronic Wound Care* (www.chronicwoundcarebook.com) and clinical editor of *Wound Source* (www.woundsource.com).

10 statements proposed by the SCALE Expert Panel:

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 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.

Statement 6
Risk factors, symptoms and signs associated with SCALE have not been fully elucidated, but may include:

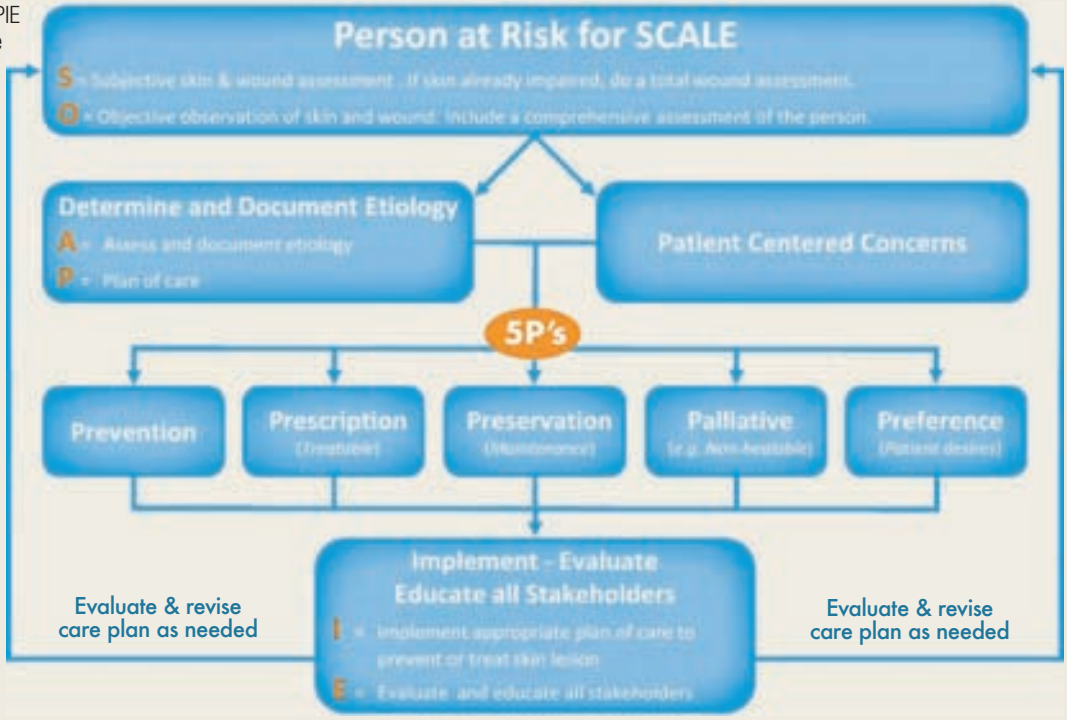
- **Weakness and progressive limitation of mobility.**
- **Suboptimal nutrition including loss of appetite, weight loss, cachexia and wasting, low serum albumin/pre-albumin, and low hemoglobin as well as dehydration.**
- **Diminished tissue perfusion, impaired skin oxygenation, decreased local skin temperature, 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.**

Statement 7
A total skin assessment should be performed regularly and document all areas of concern 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.

SCALE Final Consensus Statement

Determined as a result of a two-day panel discussion and subsequent panel revisions with input from noted wound care experts using a modified Delphi Method approach.

Figure 1: The SOAPIE mnemonic with the 5P enabler.



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 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)

S = Subjective skin & wound assessment: The person at the end of life needs to be assessed by history, including an assessment of the risk for developing a skin change or pressure ulcer (Braden Scale or other valid and reliable risk assessment scale).

O = Objective observation of skin & wound: A physical exam should identify and document skin changes that may be associated with the end of life or other etiologies including any existing pressure ulcers.

A = Assess and document etiology: An assessment should then be made of the general condition of the patient and a care plan.

P = Plan of care: A care plan should be developed that includes a decision on skin care considering the 5P's as outlined in Figure 1. This plan of care should also consider input and wishes from the patient and the patient's circle of care.

I = Implement appropriate plan of care: For successful implementation, the plan of care must be matched with the healthcare system resources (availability of equipment and personnel) along with appropriate education and feedback from the patient's circle of care and as consistent with the patient's goals and wishes.

E = Evaluate and educate all stakeholders: The interprofessional team also needs to facilitate appropriate education, management, and periodic reevaluation of the care plan as the patient's health status changes.

Statement 10

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