

## Debridement of A Decubitus Ulcer in a Cognitively Impaired Patient A Teachable Moment

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### **A Story From The Front Lines**

An elderly woman with dementia was admitted to the hospital from her skilled nursing facility (SNF) with worsening encephalopathy secondary to sepsis with a large decubitus ulcer as the presumed source of infection. She had an up to date Colorado advance directive (MOST form) documenting do-not-resuscitate status but specifying a willingness to be treated with antibiotics and medical therapy. Despite initial therapy, her sepsis progressed during her first 48 hours of admission while on intravenous antibiotics. She was then treated with broader coverage antibiotic therapy and she was referred to surgery for operative debridement of her ulcer. She unfortunately had numerous complications from her debridement, yet aggressive interventions were pursued in hopes of "infectious source control," and optimizing her outcome with medical therapy.

Due to a number of challenges, reaching family members about her advance directives and establishing goals of care proved particularly difficult. When attempting to update and discuss this patient's medical condition and probe family about what therapy was in the patient's best interest there was a lack of consensus about whether to proceed with more invasive surgical debridement of the decubitus ulcer.

After several weeks in the hospital and multiple intraoperative surgical debridements of the patient's wound to gain control of the infection, she eventually developed pneumonia with significant respiratory decline. Further conversations with family about her complicated course ultimately led to the decision transition the focus of her management to "comfort care." The patient's antibiotics were discontinued and she was discharged to an inpatient hospice facility.

### **Teachable Moment**

This case highlights the challenges faced by patients with cognitive impairment and the implementation of advance directives. While discussion of code status and goals of care is often considered a standard portion of a comprehensive medical evaluation, implementation of outlined goals of care are often not straightforward {Jeznach, 2015 #1}. Increasingly, clinicians in the ambulatory setting and skilled nursing facilities have taken on the, at times, daunting task of addressing goals of care and encouraging patients to complete written advance directives {Campbell, 2009 #9}. Moving forward, these written documents will continue to require further reassessment to see if they do in fact minimize longer hospitalizations often fraught with unexpected complications. While the implementation of advance directives has been demonstrated in some settings to improve such scenarios {Lingler, 2008 #3}, patients with cognitive impairment or advanced psychiatric illness remain particularly vulnerable to invasive medical therapies {Kemp, 2015 #8}.

At the conclusion of our patient's hospitalization, it was difficult to decipher whether her management had been within her goals of care and felt unsettling.

### **Works Cited**

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