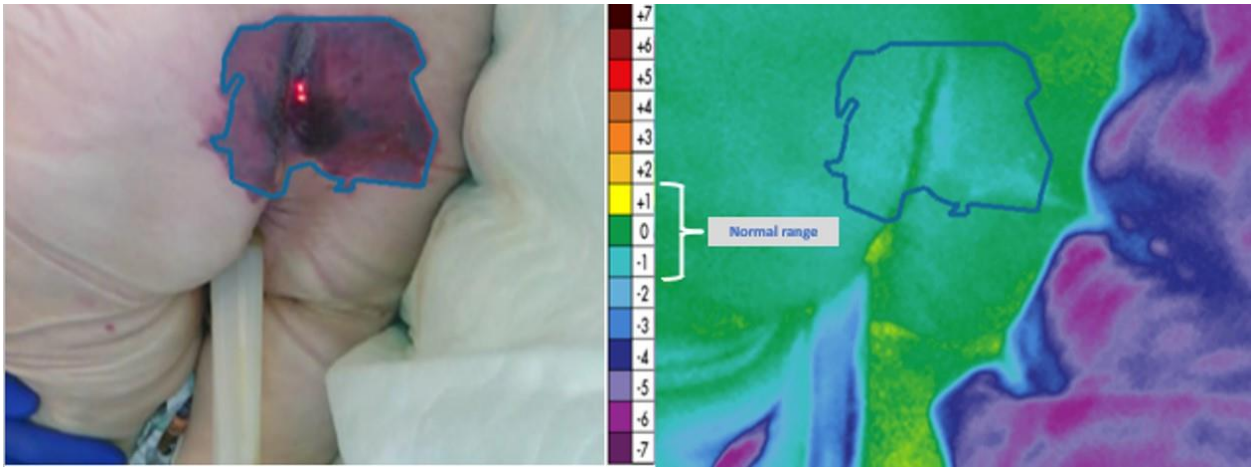
# Palliative Round Table Education

A **Kennedy ulcer** (sometimes called a *Kennedy terminal ulcer* or *KTU*) is a skin wound that develops very rapidly—often within hours to days—at the end of a person's life. It is considered a **sign of impending death** and is not the same as a typical pressure injury.




## What it is:

- **Location:** Most often appears on the sacrum or coccyx but may be seen on heels or other pressure points.
- **Appearance:** Starts as a blister, dark spot, or small skin breakdown that expands quickly. The wound edges may be irregular or shaped like a pear, butterfly, or horseshoe.
- **Color:** Can range from red, yellow, and black to purple and maroon, with mottled or necrotic tissue.
- **Onset:** Develops suddenly—sometimes within 24 hours—despite good skin care and pressure prevention.
- **Cause:** Thought to result from multi-organ failure, hypoperfusion, and skin breakdown that occurs as the body shuts down near death.

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**Why visiting nurses should know about them:** Visiting nurses should know about Kennedy ulcers because they are an *end-of-life skin change*, not a typical pressure sore. Recognizing them helps with accurate documentation, ensuring the patient receives comfort-focused care and compassionate family communication. See Examples below.

1. **Differentiation from pressure injuries**
    - Kennedy ulcers are *not caused by neglect or poor care* but are part of the natural dying process.
    - Recognizing this helps protect patients, families, and nurses from unnecessary guilt or blame.
2. **Communication with families**
    - Families may see the wound appear suddenly and feel distressed, assuming it's a preventable bedsore.
    - Nurses can explain that it is a sign the body is shutting down and often indicates death may occur within days to weeks.
3. **Clinical implications**
    - A Kennedy ulcer can signal that the patient is entering the last stage of life.
    - It prompts the nurse to reassess the plan of care; shift focus to comfort and discuss prognosis with the care team.
4. **Documentation**
    - Properly documenting the ulcer as a *Kennedy terminal ulcer* helps clarify that it is end-of-life related and not a result of missed prevention.

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## Communication with LTC staff and or family members:

### Conversation 1: Explaining What It Is

**Nurse:**
*"I want to explain what we're seeing on your loved one's skin. This wound appeared very quickly, and that's something we sometimes see at the end of life. It's called a Kennedy ulcer. It's not caused by poor care or something we missed—it's a sign that the body is shutting down. At this stage, our focus shifts to keeping your loved one comfortable."*

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### Conversation 2: Reassuring About Cause

**Family Member:**
*"Did this happen because we didn't turn her enough?"*

**Nurse:**
*"That's a very understandable worry. I want to reassure you—this ulcer isn't from lack of turning or care. Kennedy ulcers can develop suddenly even with excellent care, because the skin and organs aren't getting enough blood flow anymore. It's part of the natural process of the body preparing for the end of life."*

## Conversation 3: Preparing for Next Steps

**Nurse:**
*"The appearance of this ulcer often means that changes in the body are happening more quickly. Sometimes this can signal that death may be days or even hours away. My role is to make sure your loved one stays as comfortable as possible, and to support you through this time. Let's talk about what matters most to you and your family right now."*

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*Here is a link to Nurse Julie, where she talks about the Kennedy Ulcer.*

*https://www.google.com/url?sa=i&url=https%3A%2F%2Fwww.tiktok.com%2F%40hospicenursejulie%2Fvideo%2F7237674393948802346&psig=AOvVaw0or6YrxuIK9kjVIZ_xNWYT&ust=1755956757576000&source=images&cd=vfe&opi=89978449&ved=0CBUQjRxqFwoTCIizjvTGno8DFQAAAAAdAAAAABAS*

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## ***QUIZZ question.***

Choose the best description of a skin finding in an imminently dying hospitalized patient that would be consistent with a Kennedy Terminal Ulcer (Fast Fact #383 Kennedy Terminal Ulcer):

1. Tiny non-blanching, flat red or purple spots seen on arms and legs in clusters.
2. Large purple net-like patterns of painful lumps seen on the thigh creating difficult to heal areas of black-brown crust.
3. Swollen, boil-like red bumps that are painful and warm to touch; located on the lateral calf.
4. An irregularly shaped butterfly-appearing wound seen on the sacral region that was normal in appearance just 1 day ago, the wound is now greater than 2 cm in diameter and has multicolored discoloration.

*Reference*
This education is developed with the assistance of Clinical Resources via PC Fast Facts Now, assisted by AI. For a full list of reference please contact NSMHPCN Consultant Nancy Good-Kennedy at nancy@nsmhpcn.ca.