Is pressure ulcer classification working for clinicians?

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HN: 'I personally do not think that the EPUAP system provides an accurate, consistent and speedy approach to pressure ulcer classification'

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Pressure ulcers are now rightly regarded as a quality indicator in the UK health system. Consequently, it is imperative that they are accurately assessed, graded and managed. In any area of extant pressure damage, there is a continuum of tissue involvement, extending from changes that occur before any skin breakage, through to ulceration that may involve tendon and bone, all of which clinicians need to recognise and document. The careful assessment of the degree of tissue involvement is crucial to prognostic and therapeutic decisions.

There are many systems of classifying, or grading this damage, some of which have been in widespread clinical use for decades — for example, Ludwig Guttman wrote extensively on this topic in the 1950s (Guttman, 1955).

There have long been disputes over the classification of ulcers, as well as over the reliability and utility of grading systems (Barbenel, 1977; Healey, 1995; Bethell 2003; Nixon et al, 2005). Today, thanks to national expert panels, as well as extensive research, the situation is very different. Attempts to standardise pressure ulcer classification have been made — the American Agency for Health Care Policy and Research (AHCPR) and the European Pressure Ulcer Advisory Panel (EPUAP) have worked closely together for over 20 years to achieve this goal. However, has this made the anticipated progress that was expected at the time? There have been a number of iterations of the EPUAP guidelines in recent years, each intended to refine and improve the grading of lesions.

While various validation studies proceed, it is important to obtain feedback from interested parties on how these EPUAP developments are perceived. With grade 3 and 4 pressure ulcers (EPUAP) being seriously considered as 'never' events in the NHS, validity, ease of teaching, accuracy and ease of use for both frequent and infrequent users are crucial requirements in any grading system. One could reasonably argue that any system has to be accessible to the least-skilled member of the team.

The implications for patients, clinicians, and hospitals is immense. Thus, we have invited Mike Clark, Chairman of EPUAP, and Heather Newton, an experienced tissue viability nurse, to contribute to this debate.
Richard White

How useful is the EPUAP 2009 revised pressure ulcer classification system?

MC: As EPUAP President, I may be biased, but I feel that the 2009 revised pressure ulcer classification system has meant that ambiguities of language that existed in earlier schemes have been removed, for the first time allowing Europe and the US to share a very common vocabulary when discussing pressure ulcers.

HN: Historically, pressure ulcer classification systems have been used to enable clinicians to determine the extent of pressure damage through describing the tissue involved and the depth of damage. I am not convinced that the revised classification has added any value to the original 1999 system, apart from providing a more detailed description within each category. However, without underpinning education and training, it is still not simple enough to provide consistency and validity for those staff who do not use the tool regularly enough or who have had minimal training.

Have the changes to the categories/ grades made a difference to the clinical classification of ulcers?

MC: The 2009 revision of the classification system has helped clinicians to be more consistent in distinguishing category 3 from category 4 ulcers — it has also helped the perennial problem of separating category 2 and 3 ulcers. One challenge from the pre-2009 guidance was that if a pressure ulcer was totally covered in dry eschar it was to be considered to be at least a category 3 ulcer, leaving clinicians unsure how to classify these wounds.

HN: A decision was made between the 1999 and 2009 classifications to change the terminology from 'grade' of pressure ulcer to 'category/ stage' of pressure ulcer. But was this really necessary? It appears that the rationale for this change was that the term 'grade' indicated a possible deterioration, but surely this *is* what happens between a grade 1 and a grade 4 ulcer! I personally feel that there has been over-reporting of pressure damage since the changes in the classification system. Any pressure ulcer that exhibits slough can now be classified as a grade 3, regardless of the depth, as the description of a grade 2 excludes the presence of slough. Surely the grade of damage to the tissue should relate to the depth of damage and not just the characteristics of the wound bed. Incorrect grading also occurs when dried-up haemoserous blisters are classified as a grade/stage 4, when, in fact, they are often found to be superficial once the eschar has been removed. There appeared to be less confusion with the Sterling classification system than the EPUAP system because the categories were further broken down to enable a more accurate assessment. However, some argue that this was too complicated.

How practical and accurate has the EPUAP system proved to be so far?

MC: The 2009 classification system is certainly practical as evidenced by its widespread adoption within the NHS. As for accuracy, this has been increased by the more explicit separation of the categories, which, in the past, gave rise to challenges. For example, the statement that a pressure ulcer containing slough is a category 3 ulcer helps to distinguish it from a category 2 ulcer.

HN: I am not convinced that the EPUAP ensures accuracy in pressure ulcer classification, but am also not sure that other tools that we use to assess risk and level of pressure damage are any more valid. There are many variables that might affect the accuracy of a system, such as the knowledge and skill of the practitioner and the potential for under- or over-grading through different levels of professional competency. At times, even the most experienced tissue viability nurses struggle with accurate assessment of the depth of skin damage. Images of skin breakdown are easier to follow than descriptors, but sometimes there is simply a need to watch, relieve pressure and wait! Mentioning the absence of bruising in category 2 has also caused confusion, as bruising is not described in any other category and is not necessarily related to pressure damage. The accuracy of the EPUAP system remains a concern for many staff, especially between categories 1 and 4. This is because the true extent of tissue damage is not always visible, which then affects the accuracy of reporting of the category 4 damage.

Image: Files. Credit: EvelynGiggles on Flickr.

Too much information: an overload of guidance and paperwork can lead to confusion among clinicians.

Is there any evidence that clinicians are/ are not adopting it across the UK?

MC: There is widespread anecdotal evidence that the revised classification system is commonly used across the NHS. Again, anecdotally, it would appear that some clinicians are also adopting two categories — 'unstageable' and 'deep tissue injury' — which are used in the US but have been left out of the European classification.

HN: It would appear from the national pressure ulcer consensus meeting that a large number of trusts are now using the EPUAP classification system. As clinicians, I am sure that the majority of us are not against a nationally recognised classification system, however, it does need to be simple, valid and reliable for use by staff at all levels. It was also evident that some areas are also using the terms 'deep tissue injury' or 'unstageable' where classification using the four-stage EPUAP category is not achievable.

Is the EPUAP system addressing the need for accurate, consistent and speedy classification of ulcers in the NHS?

MC: By and large, the EPUAP 2009 revised classification system is fit for purpose, although there is perhaps a need to reintroduce the advice upon wounds that are covered by dry eschar. More work is required to address the validity of including deep tissue injury as a category, as it is currently unclear how many apparent deep tissue injuries resolve without becoming full thickness wounds. Clinicians will shortly be able to access a revised training tool — PUCLAS 3 — from the EPUAP, which should help them use the classification system with greater confidence. The draft PUCLAS 3 was available on the EPUAP website until 5 November, 2012 for evaluation and comment, and the final version will appear shortly, in 2013.

HN: I personally do not think that the EPUAP system provides an accurate and consistent approach to pressure ulcer classification. However, on a positive note, at least the majority of us are now assessing the level of tissue damage regularly, regardless of the reliability of the tool. I am sure tissue viability nurses' workload would decrease if they were not being called upon to validate pressure damage because other staff are not confident in using the EPUAP tool. A simple nationally adopted system is required, potentially with less categories. WUK

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