# National Wound Care Strategy update: pressure ulcer consultation

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In April this year we consulted on the new National Wound Care Strategy Programme (NWCSP) pressure ulcer (PU) clinical recommendations and clinical pathway. There were 187 people from across England who completed the consultation (*Figure 1*). The respondents were mostly from acute or community trusts, with a small number of responses from general practice, care homes, commercial companies, commissioning organisations, as well as patients and their carers.

The feedback generally confirmed that the pathway was easy to follow and that the suggested changes were mostly welcome and long overdue. There were also a good number of strong and well thought through challenges, which have led to some minor amendments in the recommendations and strengthening of the explanations.

Broadly speaking, these challenges related to eight key themes:

- When does the clock start for risk assessment in acute organisations (and how much of the assessment must be completed to meet this criteria)?
- Concerns around virtual assessment
- Concerns about the move to different risk assessment tool
- Uncertainties about frequency of reassessment
- Uncertainty about PU categorisation
- Uncertainties about the definition of device-related pressure ulcer (DRPU) or medical device-related pressure ulcer (MDRPU)
- Concerns about referral to surgeons for hard-to-heal PUs
- Issues relating to 'every contact counts'.

## When does the clock start?

The recommendation that risk assessment should be completed within six hours of admission comes from the National Institute for Health and Care Excellence (NICE) quality standard (NICE, 2015) which recommends that:

*'People admitted to hospital or a care home with nursing have a pressure ulcer risk assessment within six hours of admission'.*

However, no further detail is provided within the NICE quality standard. The aim is to add clarity by recommending that in the acute setting, the six hours begins at the point that the patient is first seen by a registered healthcare professional. This brings the statement in line with the NICE quality standard for community assessment which is 'at first visit'.

To illustrate, for patients admitted via the emergency department, this means that risk assessment should be completed within six hours from when the patient is seen by a registered clinician (most likely the triage nurse). There is no requirement for the triage nurse to complete the whole assessment, but within the following six hours the remainder of the risk assessment process should be completed. So, if the triage nurse uses step 1 Screening of the PURPOSE T tool (*Figure 1*) and ticks only blue boxes, which identifies that they are on the green pathway (not at risk), then that completes the assessment. If, however, they identify pink or yellow boxes, this indicates that Step 2 full risk assessment should be completed so, to achieve the risk assessment within six hours, the full assessment must be completed within that time frame.

## Virtual assessment

The NWCSP clinical recommendations state that it should be documented whether assessments were in person or virtual (contact via telephone or video). Some respondents were vehemently opposed to the use of virtual assessments in the community, but the recommendations do not suggest that virtual assessment of either risk or skin should be a normal practice, but that for a small number of patients it may not be possible to do an in-person assessment. This may be due to the patient's mental health, or a safety concern for the healthcare professional.

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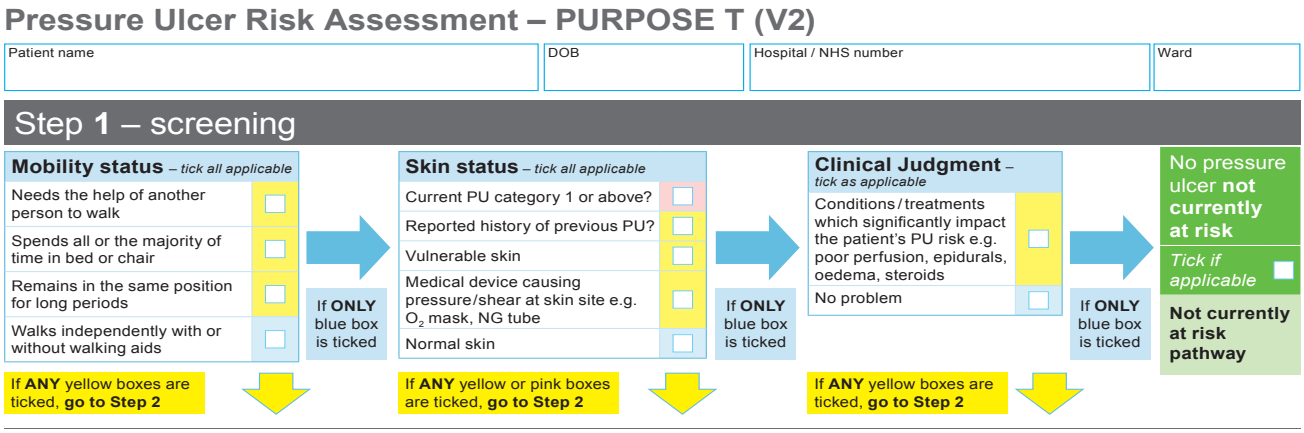


**Figure 1. The screening component of the PURPOSE T tool**

Where virtual ward systems are in place the patient may not be seen at all unless concerns are raised and this is another area where a virtual assessment may be considered. If it is necessary to perform a virtual assessment, this must be clearly recorded along with the rationale. Where possible a family member or carer should be with the patient to assist with the skin check. For this, video calling is preferable to audio calling.

## Use of a single risk assessment tool

The NWCSP decision to only recommend the use of the PURPOSE T risk assessment tool was challenged on the grounds that this did not align with the with the 2014 NICE clinical guideline and did not recognise the hard work that has gone into adoption of other risk assessment tools within local organisations.

The 2014 NICE clinical guideline pre-dates the publication of PURPOSE T and at the time of the 2018 review of the NICE Clinical Guideline, there was limited evidence of the use of PURPOSE T so no amendments were made in that update. However, since then, the evidence in support of PURPOSE T has grown and PURPOSE T now has the strongest supporting research evidence of any PU risk assessment tool (*Table 1*).

As a compromise to assist those who feel they have good outcomes for their existing tool, the wording in the NWCSP recommendations has been amended to say, "use the PURPOSE T risk assessment tool or any other tool which, as a minimum, contains the same risk factors" (i.e., immobility/analysis of movement, sensory perception, perfusion, nutrition, moisture, diabetic status, skin status and the presence of a medical device) as these have been identified as direct causal or key indirect causal factors in PU development (Coleman et al, 2014b). For organisations using a tool other than the PURPOSE T, the clinical pathways (green, orange and red) still apply as all tools should differentiate between those not at risk (green) those at risk but without a PU (orange) and those at risk with and existing PU (red).

## Frequency of reassessment

Several respondents found the recommendations about the frequency of reassessment confusing. The wording has been amended to make it clearer that the recommendations for reassessment should be viewed as hierarchical:

- If condition changes
- At the pre-planned interval

**Table 1. Research undertaken to support the use of PURPOSE T**

- Systematic review of pressure ulcer risk factors (Coleman et al, 2013)
- Conceptual framework development (Coleman et al, 2014a)
- Consensus study (Coleman et al, 2014b)
- Patient involvement in risk tool development (Coleman et al, 2015)
- Pre-test (Coleman et al, 2016)
- Clinical Evaluation (Coleman et al, 2018)

- At regular intervals (and what is meant by regular).

Priority should be given to any change in condition (whether a change in environment or circumstances) as this is when the risk is most likely to change, so this overrides the timing of any pre-planned reassessment.

If the condition of the patient is stable, then reassessment should occur at a date pre-planned at the previous assessment. The pre-planned date should have considered the patient's risk category and the individual risk factors that make up that risk status.

The NWCSP Clinical recommendations had not made a recommendation about the minimum frequency of reassessment because this should be based on the needs of the individual patient. However, many respondents asked for clarification. A statement has been added that says a planned re-assessment should, as a minimum, be at least once a week in hospital and at least once a month in a community setting including care homes. Where patients are seen less frequently than monthly for example every three months to administer B12, the reassessment should be at every visit.

## Pressure ulcer categorisation

The NWCSP Clinical Recommendations propose amending the current categorisation system (NHS Improvement 2018 and 2019) to just four categories. (plus, mucosal and device related) and dropping the previous 'holding categories' of 'Unstageable' and 'Deep Tissue Injury'. This was the change of most concern to respondents,

For many organisations the verification and reporting of the 'correct' category of PU is incredibly time consuming but this verification and reporting activity appears to have no impact on the care delivered to patients or relate to the level of harm the patient sustained either in the old Safety Incident framework (https://www.england.nhs.uk/patient-safety/serious-incident-framework/) or the new Patients Safety Incident Response Framework (https://www.england.nhs.uk/patient-safety/incident-response-framework/)

The NWCSP Clinical Recommendations propose that as a minimum, an unstageable PU must be a category 3 as the definition states that it is a 'full thickness tissue loss' Current practice is that these PUs are followed until the true extent of damage is observable and they should then be re-categorised as a 3 or 4. Data suggests that only a small number of PUs within the system ever become a category 4 (for April 2023 only 4.9% of PUs nationally were categorised as a category 4 compared with 20.3% categorised as unstageable (data from the Model Health System). If all the previously unstageable PUs were initially recorded as a category 3, only a small number would need to be changed to a category 4. This would release considerable clinical time with little if any change to PU care.

Deep tissue injury (DTI) is also a holding category. It implies damage deep in the tissues that cannot be visualised so is effectively another term for 'unstageable', the only difference being that in DTI the skin is unbroken. Feedback from clinical staff suggests DTI is often incorrectly allocated to bruises, vascular events or vasopressor use (which rapidly resolve) rather than PU damage. Only a small number of DTIs evolve into open PU damage but again, much clinical time is spent following up these wounds with little patient benefit. Respondents were concerned that removing DTI as a category would result in inadequate care and monitoring of such vulnerable skin, but PURPOSE T includes 'vulnerable skin' so supports the delivery of appropriate care. Should vulnerable skin break down, once the full extent of the damage is visible the PU can be appropriately categorised. While it may not be reported at this stage all vulnerable skin should be recorded, photographed and monitored for any changes.

It appears that some DTI especially those on the heel neither resolve nor evolve i.e., the skin does not break but there is clearly underlying tissue damage. In these cases, the guidance on category 4 should be applied, which suggest that category 4 can be allocated if 'exposed bone/tendon is visible or directly palpable'. If there are very strong requirements to maintain the use of these terms the wording should be amended to say:

- Unstageable as a minimum category 3
- Or suspected deep tissue injury — which must be re categorised within 72 hours.

## Device related pressure ulcer (DRPU) versus medical device related pressure ulcer (MDRPU)

The published literature uses the terms DRPU and MDPRU almost interchangeably, (with papers and presentations appearing to vie for the most outlandish cause of a DRPU. The most common example appears to be a TV remote control!)

For the purpose of the NWCSP Clinical Recommendations it was important to distinguish between these two similar but different terms by

addressing the context in which they are used. In the NWCSP Clinical Recommendations the focus is on identifying risk and carrying out the relevant preventative actions, so the device needs to be one where the clinician could reasonably have predicted the risk. Therefore, it is recommended that the term MDRPU should be the preferred term, as a medical device is something that is used with clinical intention so risk can be predicted and managed by the clinician. MDRPU includes pressure damage from any medical equipment that is in contact with the patient so can be anything from a catheter or endotracheal tube to the mattress or the cushion on which the patient is sitting. It does not encompass anything that is accidentally dropped by the patient or their family in and around their chair or bed, such as the TV remote control as this is not clinically intentional, so risk could not reasonably be managed by the clinician.

### Referral to surgeons

Many of the respondents' concerns about referral to surgeons for category 3 and 4 had not appreciated that the phrasing is to 'consider referral' rather than 'make a referral'. Their concerns included anxiety about organisations' ability to support a flood of new referrals. The ordering of the bullet points has been amended to make it clearer that this recommendation is for when all usual wound care treatments have already been tried and when a referral for surgery is acceptable to the patient. The recommendation has also been clarified to recommend the patient being assessed by a member of the surgical team rather than by the surgeon to reflect good practice in Plastic Surgery Outreach services.

### Every contact counts

The NWCSP Clinical Recommendations set out what best practice should look like. Expecting every healthcare practitioner to be aware of PU risk and know what to do is aspirational, but inclusive. PU prevention is not just a nursing responsibility — every contact really does count, so other health and social care practitioners play an important role in preventing pressure damage. For example, physiotherapists support activity and mobility, and paramedics are often the first to see someone following a fall in the home when the patient may be at their most vulnerable. Such professions have demonstrated their willingness to engage in both risk assessment and prevention (Mains et al, 2020; Schroder and Downie 2021). Identification of those at risk or those where risk is increasing due to increased frailty, or an acute change should be something that every health or care practitioner knows about along with knowing what to do to reduce risk.

## CONCLUSION

The purpose of the clinical recommendations is to set out what best practice looks like. Some of the recommendations may feel like stretch goals but they should all be achievable. The NWCSP Clinical Recommendations are supported by research evidence so will be updated on a regular basis as new evidence emerges.

A pilot of implementation is due to take place later in autumn, with the diagnostic phase helping to plan what level and type of implementation support may be required to implement and embed the recommendations across NHS England. WUK

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