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A survey of society of tissue viability members in response to the pressure ulcer categorisation recommendations made by the national wound care strategy programme

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1. Introduction

The National Wound Care Strategy Programme (NWCSP) was commissioned by NHS England, designed to improve the wound care provided to every patient across the UK [1]. The programme developed recommendations for three streams:

1) Pressure ulcers
2) Lower limb and foot ulcers
3) Surgical wound complications

In May 2024, NWCSP published their proposed changes to the categorisation of pressure ulcers in England, recommending using Categories 1–4 or mucosal [2]. This included:

- "Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formerly referred to as 'unstageable') should initially be recorded as Category 3 pressure ulcers immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration."
- "Deep tissue injuries (DTIs) should not be reported as pressure ulcers unless they result in broken skin or they fail to resolve and it is evident on palpation that there is deep tissue damage present, at which point, they should immediately be categorised and reported. However, the skin change must be recorded within the clinical record (for example by ticking the vulnerable skin option in the PURPOSE-T tool) and appropriate preventative care delivered as soon as the damage is noted."

Nationally there was debate at conferences and on social media by healthcare practitioners, with varying uptake of these recommendations. There have also been surveys and publications critiquing the proposed changes [3,4]. They were brought to and discussed at the Society of Tissue Viability (SoTV) Trustees meeting in July 2024. The SoTV is the UK's first multidisciplinary wound prevention and healing society, set up over 45 years ago. It is a member led charity providing education, training, and expertise, led by a team of members elected to Trustees positions. The Society's Board of Trustees is made up of 16 healthcare professionals and 2 industry representatives, with expertise in the field of wound healing. Following debate and discussion amongst the trustees, it was decided that as leaders in the field of wound prevention and healing, the SoTV needed to address these recommendations.

The new proposed classification system was debated amongst the SoTV trustees, revealing potential benefits and limitations. These were and are summarised in Table 1.

As a result of the comments raised above, consensus was achieved regarding the proposed changes, and a statement was produced and published on the SoTV website to represent the views of the Trustees [6]:

> "The SoTV Trustees do not currently endorse the proposed changes based on the balance of views cited above. In order for change to occur successfully, the Trustees feel that there needs to be wider engagement across health and social care regarding the proposed plans. In addition, piloting and evidencing the benefits of change need to be established. This could then be presented to the wider national and international communities to share the benefits and gain further consensus on changing the model of classification. Without the community getting behind any proposed classification change, there is a risk that it could create further confusion between healthcare professionals and care sectors and limit our ability to benchmark improvements in care provision and patient outcomes, which underlines our aims as a Society.

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Table 1
Benefits and Limitations of the new NWCSP classification system.

Benefits	Limitations
The new method of classifying pressure ulcers may simplify skin/wound assessment for clinicians. There may also be less ambiguity regarding specific types of skin changes, for example deep tissue injury.	There is no current evidence that the proposed system is any better than the existing internationally recognised categories and further rationale is required.
The new system also questions some of the historic context around deep and superficial pressure ulcers, where bony prominences e.g. heel or bridge of the nose, typically have limited tissue coverage.	There appears to be limited piloting or testing of the system prior to the proposed roll out, with transparency needed regarding the outcomes/impacts of any sites which have adopted the new system.
Colleagues from SoTV strongly agree that there is a need for more anatomy training and better visual representations of pressure ulcers.	There are concerns over terms such as 'vulnerable skin', whereby clinicians may not be alerted to the serious nature of potential skin damage (compared to Suspected Deep Tissue Injury). Generalists need to have a recognised alert system to trigger care provision. There is a need to avoid any ambiguity.
There is recognition that there are limitations with the current categorisation system, with both specialists and non-specialist healthcare professionals challenged to diagnose pressure ulcers accurately and reliably [5].	If England unilaterally changed its process for classification, this would impact with practice and shared learning across the UK and with our international colleagues.
	Any change to categorisation needs careful planning to ensure successful implementation, with education across care sectors required. Without this collective effort, it's unlikely any new system will be successful.

The Society recognises the work that has been undertaken to create the new recommendations for pressure ulcer categorisation and are committed to working with colleagues within NHS England/NWCSP to support best practice. We understand the need to remove any barriers of care and ensure pressure ulcer prevention and treatment is delivered in the most effective way. We are more than happy to work with all relevant parties to address the concerns raised above, and work towards a solution that benefits not only SoTV Trustees, but also the diverse communities we serve".

To ensure that the statement reflects not just the opinions of the SoTV Trustees, but also our members, it was decided that our members should be given the opportunity to respond to our statement and to hear their thoughts on the proposed changes from the NWCSP. The aim of this paper is to collate the opinion and feedback from the SoTV members community.

2. Methods

Following publication of the statement, SoTV members were invited to complete a short, anonymous online survey. SoTV members include a wide range of healthcare practitioners with an interest in skin and wound healing as well as academics, educators, and industry. The survey was sent to all members via email, along with a social media campaign to increase uptake.

They were first asked:" Do you agree with the SoTV statement regarding the proposed changes to pressure ulcer categorisation in England?" Members were then given the opportunity to provide open ended comments to provide a rationale for their answer and to comment on the proposed changes and the SoTV statement.

The survey was anonymous, thereby not requiring ethical approval. A thematic analysis of the members' responses and comments was undertaken using a combination of inductive and deductive coding [7].

3. Results

The survey was open for 2 weeks with all members invited via email and through the website to respond. A total of 108 members fully completed the survey (approximately 10 % response rate). There was a 73.15 % agreement with the SoTV statement regarding the proposed changes to pressure ulcer categorisation in England (Table 2). 90/108 members who completed the survey also provided comments regarding their answers. The 90 comments were broken down into 152 different codes, which were collated as themes emerged.

3.1. Themes identified

3.1.1. Categorisation: DTI versus vulnerable skin

The most common theme that came from the responses, whether they agreed with the SoTV statement or not, was how suspected DTIs are recorded, with 39(43 %) respondents discussing this. Concerns with the changes included that potentially serious skin damage could be miscategorised as vulnerable. Vulnerable skin was incorporated into the PURPOSE T risk assessment to recognise skin that is more at risk of pressure ulcer development, e.g. redness, persistent blanching erythema, dry or oedematous skin [8]. In contrast, a suspected DTI represents potential pressure damage to the deeper sub-dermal tissue, and it was therefore felt by many that they shouldn't be in the same category. This was reflected in a similar survey conducted by the Wound Care Alliance, where 88 % of respondents expressing the view that DTIs should continue to be recorded as a category of pressure damage [4].

There were also concerns that if vulnerable skin was used instead of suspected DTI this might impact the care provided for the patient and whether appropriate proactive interventions would be implemented. This could be from whether vulnerable skin would trigger a patient review, and if staff would recognise the level of risk. Some respondents were concerned that if a patient with 'vulnerable skin' was transferred between care environments this would not trigger the same level of care/interventions as if the patient was described as having a suspected DTI. This could cause a delay in assessment and implementation of interventions, which may increase the risk of the skin deteriorating.

Respondents who were in favour of the proposed changes reported that their experience had been that most suspected DTIs were superficial or healed within 2 weeks, therefore felt they weren't true DTIs. It was also felt that it was simpler and that these pressure ulcers should only be reported if it fails to resolve or if deeper damage was evident on palpation.

3.1.2. National/international consensus

One of the main oppositions to the proposed changes was that it was felt that the NWCSP recommendations were brought out prematurely without consultation with international bodies e.g. European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP)and the Pan Pacific Pressure Injury Alliance (PPPIA). 21/90 (23 %) of respondents reported that classifications should be the same internationally, not just for simplicity, but also for international transferability of research and ability to share learning from pressure ulcer incidents. There were also concerns that these recommendations were just for England, rather than a four nations approach across the UK.

Table 2
Results from members survey.

	Yes	No	Not sure
Q1: Do you agree with the SoTV statement regarding the proposed changes to pressure ulcer categorisation in England?	N = 79 (73.15 %)	N = 20 (18.52 %)	N = 9 (8.33 %)
How many provided open ended comments regarding their answers	N = 65/79 (83 %)	N = 16/20 (80 %)	N = 9/9 (100 %)
Total number of codes provided	94	38	20

3.1.3. Evidence base

Concerns about the lack of the evidence base or research to support the recommendations was discussed amongst 22/90 (24 %) respondents. It was felt that the proposed changes do not support the contemporary research regarding pressure ulcer aetiology [9], and that any changes made should have a strong evidence base or scientific rationale. Respondents discussed following evidence-based practice, and they might have been more supportive of the change if there was strong evidence to support the recommendations. Respondents' suggestions included research on the impact of the proposed changes on both the staff and patients involved, as well as a feasibility study prior to roll out.

There were also concerns about how these changes could impact upon research taking place, including learning more about the evolution of DTIs, with the new recommendations limiting the data researchers can collect with regards to this type of injury. With reporting and categorisation being different on an international basis, this could impact the transferability of research findings.

Those both for and against the changes stated more needed to be learnt about heel DTIs, as most research evidence describes DTIs as starting at skeletal muscle [10] and there is no skeletal muscle at the heel [11].

3.1.4. Roll out/Implementation issues

The impact on training and education packages was discussed by 15/90(17 %) respondents; both in favour and against the proposed changes. Those in favour felt that it would simplify training packages, whilst those against were concerned about the additional training that would be required to implement the changes. Both sides felt that a standardised/robust training platform should have been provided to support implementation of the changes.

17/90 (19 %) respondents either against the proposed changes or uncertain about them discussed the impact the changes would have on 'general nursing staff'. There were concerns about 'ambiguity' and that there could be an increase in misdiagnosis. As a result, appropriate interventions may not be implemented if suspected DTIs are categorised as vulnerable skin. Inexperienced staff might not be able to intrinsically recognise the risk difference between skin reported as vulnerable because there is a suspected DTI which could be early signs of pressure damage, or dry skin that is also recorded as vulnerable. None of those who provided comments and were in favour of the proposed changes discussed the impact the changes would have on 'general nursing staff'. No respondents discussed the impact the proposed changes would have on other healthcare professionals.

3.1.5. Lack of consultation/involvement in the proposed changes

15/90(17 %) respondents to the survey both in favour and against, expressed concerns about there being a lack of public engagement/consultation with clinicians about the impact of the proposed changes. It was felt that the recommendations should have been trialled/piloted prior to implementation. It was acknowledged that respondents appreciated the opportunity to be able to express their opinions through this survey and to feel listened to.

3.1.6. Patient focused care

Respondents both in favour and against the proposed changes expressed concerns about the recommendations being focused on reporting/coding of pressure ulcers, rather than the impact that it could have on patients' care. Pressure ulcer preventative care and recognising at risk patients should be the focus. Some respondents reported that validation/categorisation of pressure ulcers was a time-consuming part of their role, taking them away from direct patient care and quality improvement projects.

3.1.7. Focus is on coding/reporting

There was agreement amongst respondents that there is variation between organisations on how pressure ulcers are coded and reported. It is acknowledged that these recommendations are designed to minimise this variation. However, there were concerns that these recommendations were focused on restrictions with International Classification of Diseases version 10 (ICD-10) coding system over what is best for the patient. These recommendations will mean that DTIs and unstageable pressure ulcers will be included in the reported incidents rather than being recorded as 'unspecified'. ICD-10 is well established globally, and it was discussed in the responses that other European countries, including Germany, already use ICD-10 which does not include unstageable and DTI. However, it is not known what categorisation system these countries use, whether they follow international guidelines or categorise as per ICD-10, and whether there is the same variation between organisations as seen in the UK. The accuracy of the ICD-10 is also reliant on the clinical coders to have the relevant clinical records and can accurately interpret them [12].

Two of the respondents who were not sure about the response to the recommendations both described how under-reporting of pressure ulcers was common across the UK because of the additional paperwork required to complete incident reports, and they didn't feel that the proposed changes would make a difference to this. There were also comments on recording suspected DTIs as vulnerable skin would not improve coding and accuracy of reporting.

There were also concerns that as the proposed changes were recommendations, rather than mandatory, this could lead to individuals and organisations to interpret and adopt the changes in a way that best suits their organisation. A number of respondents felt that regardless of whether they were for or against the recommendations, there should be a standardised mandatory approach implemented by all.

3.1.8. Other comments

Respondents that had reported that they had already implemented the changes reported that it had taken a lot of time through training and education and therefore wouldn't wish to change again.

Another respondent, who did not support the SoTV's statement, and had implemented the proposed changes in their clinical area, expressed concerns over the use of social media in response to the NWCSP. They felt it was not an accurate depiction of opinions, as those who opposed the proposed changes were more vocal than those in support. It is not possible to get a national consensus without approaching all clinicians, but the clinical group involved in the NWCSP document agreed with the proposed changes. There were however respondents who reported not being aware of the proposed changes or fully understanding them.

4. Discussion

Although most respondents agreed with the Statement from the SoTV, overall whether for or against the recommendations, the members felt that there was not enough consultation by the NWCSP prior to publication. Implementation of the recommendations using change models proposed by the NHS [13], including an open public consultation prior to the publication of the proposed changes could have helped and made clinicians feel listened to, which in turn could have increased uptake of the recommendations. It was also felt that if there was a standardised training programme or resources that could be used to help implement the changes they might have been received more favourably.

Respondents reported that the proposed changes were too heavily focused on reporting and coding issues, rather than what is best for the patient and the impact it might have on the care provided, especially communication of 'vulnerable skin' between care teams. It was felt that the NWCSP changes to categorisation was focused on the standardisation of reporting practices rather than on the evidence based. There was agreement that there should be a standardised approach to categorisation, both across the UK and internationally, with a mixture of respondents being in favour of the NSWSP approach versus EPUAP/NPIAP/PPPIA. There is potential for future work exploring how different

countries categorise, report, and monitor pressure ulcerations through ICD-10 coding.

Presented in this paper are the results of a simple, open questioned survey that was sent to members of SoTV. Consent for publication of comments could have strengthened the findings of this paper and allowed for verbatim quotes, however it was decided that the results should be published, and the methodology chosen in this analysis allowed for this whilst maintaining anonymity of the respondents.

5. Conclusions

There is still too much ambiguity in categorisation, with differences between organisations on how pressure ulcers are categorised and reported. Whilst it is acknowledged that the NWCSP's approach was to reduce this, the overall feelings were that there was too much of a focus on standardisation and reporting, rather than on the patient. Overall feedback was that suspected DTIs are a potential patient harm, with interventions missed if this level of pressure damage was referred to as 'vulnerable skin'.

It has been recognised the need for pressure ulcer categorisation to be standardised, however it was felt that it should have been done in line with international guidelines, which are based on research evidence as well as consensus from an international panel of pressure ulcer experts. If the issues were with ensuring ICD-10 coding is standardised, then surely the ICD-10 categories should reflect international guidelines and recommendations instead?

This was a simple survey aimed at gaining the perspectives of the members of SoTV. The statement was published based on the consensus of the Trustees for SoTV and could have been strengthened by incorporating the perspectives of our members, however the findings of this survey has demonstrated there is consensus.

Declaration of interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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