Pressure Ulcer scope SH subgroup feedback (Groups 1-7) **Date: 10th October 2011, 10am – 1pm**	

3.1 Population:
3.1.1 Groups that will be covered:
 	
3.1.2 Groups that will not be covered:
 	
Is the population appropriate? Are there any specific subgroups that have not been mentioned?
	<u>Group 1</u>
	Groups which should be included:
	• Neurovascular disease
	• The elderly – as they are the largest group of people affected.
	• Bariatric patients – these are a growing group.
	
	<u>Group 2</u>
	• Groups which should be included:
	  ○ Neonatal
	  ○ Bariatric
	  ○ Paediatrics
	  ○ End of life
	  ○ Surgical patients.
	• The addition of older people to groups in brackets was favoured.
	• 4.1.1b) a. Delete this sentence and replace with those in 'long term need'.
	• 4.1.1b) b. Delete this sentence.
	
	<u>Group 3</u>
	• Groups which should be included:
	  ○ People with peripheral neuropathy
	  ○ Maternity
	  ○ People in long surgery
	  ○ People undergoing clinical assessment
	• A discussion took place on what was meant by 'all settings where NHS care is provided' given that care may also be commissioned in the community.
	• The group felt that the phrase 'people who are bed or chair bound' should be reworded to 'wheelchair users'.

	<u>Group 4</u>
	• Groups which should be included:
	  ○ Bariatrics
	  ○ Spinal cord injury – better described as “neurological conditions”, take out “chair bound” and say “muscle wasting” – differentiate between short term vs. long term
	  ○ The group questioned why peripheral arterial disease is specified, rather than, for example, diabetes.
	  ○ Need to consider patients in palliative care
	• Could we say “People who are more at risk of developing these conditions (e.g. xxx)”
	• Healthcare setting:
	  ○ Need to clarify it includes social care – i.e. nursing homes
	  ○ Can we say “NHS funded” rather than “where NHS care is provided”
	
	<u>Group 5</u>
	• Elderly people with cognitive impairment (as this group may have multiple co morbidities and are at high risk - many tools are not used effectively in this population)
	• Diabetics
	• People with spinal cord injury (as opposed to those who are bed/chair bound – as someone with spinal cord injury may be mobile)
	
	<u>Group 6</u>
	• Groups which should be included:
	  ○ people with neurological defects
	  ○ people who develop pressure ulcers from medical devices
	  ○ people with a previous history of pressure ulcers
	  ○ people who have had an accident which leads to a pressure ulcers because they are unable to feel the injury
	  ○ people undergoing end of life care (it was noted that there is a consensus document regarding end of life care available)
	• The group were uncomfortable with the phrase “bed or chair bound” and stated that everybody

	with mobility limitations were at risk. • The group noted that people with spinal cord injury do not necessarily have the highest prevalence of pressure ulcers – the group felt that the elderly are more at risk. They noted that the duration of risk was the key issue – people with spinal cord injuries have a longer life expectancy and their level of risk is not perceived as critical. • The group felt that the term 'people with spinal cord injury' was too specific (for instance, why not include patients with MS) and that it may be more appropriate to include people with spinal cord injuries in a broader group called 'people with long term or lifelong disabilities'. • The group felt that diabetics should be included as a specific population, particularly given that clinical judgement is needed to distinguish pressure ulcers from diabetic foot ulcers. It was agreed that, given existing NICE guidelines on the management of diabetic foot ulcers, patients with diabetic foot ulcers should be specifically excluded. • There was some discussion regarding the inclusion of preterm babies and neonates. It was noted that this is a population with a distinct skin type. Clarification is needed in the scope regarding the definition of the term 'infant'. • The group felt that it may be appropriate to exclude patients with peripheral arterial disease as they suffer from different ulcers to the rest of the population. • The group agreed that clarification was needed on whether the guideline is applicable to private healthcare, for instance, nurses treating patients in private nursing homes. <u>Group 7</u> • There was some discussion about whether the guideline would be applicable to those working in independent healthcare settings as the healthcare setting currently states that it is applicable to 'all settings with NHS care is provided'. • The group discussed whether the guidance would be implemented by general practice. • It was noted that diabetics aren't currently an excluded population, however the management of diabetic foot ulcers is excluded as this is covered by existing NICE guidance. • It was noted that, rather than including peripheral arterial disease as a subgroup, it might be more appropriate to include people 'with sensory impairment' as a subgroup. • The group requested the inclusion of pressure ulcers caused by equipment e.g. CPAP, tubing etc.

3.3.1 Key clinical issues that will be covered:
 	
3.3.2 Key clinical issues that will not be covered:
	<u>Group 1</u>
	• Need to define pressure ulcers as there is not a consistent definition e.g., avoidable, unavoidable pressure ulcers. Differential diagnosis may include moisture lesion, Kennedy terminal ulcer, and incipient pressure ulcers.
	
	4.3.1 a) Risk Assessment Tools:
	• The group did no feel these to be an area of high priority as these often vary regionally.
	• There are key elements in tools which should be focused on.
	• Nutrition screening tools are needed.
	• Most important is interaction with the patient.
	• May be useful to recommend that some tool is to be used but no preference over which is used.
	
	4.3.1 b) Prevention of pressure ulcers
	• If devices to be covered, need to add in positioning.
	  ○ Not feel that need to cover devices.
	  ○ There is just a hierarchy in cost.
	• Nutritional screening tools.
	• Patient education is vital.
	
	4.3.1 c) Management of pressure ulcers
	• Ulcer assessment tools – grading of ulcers is very contentious. There is different grading because of different tools, which results in differing severity. This has a forward effect on access to services and the type of devices e.g. mattresses that are provided. Take note of the EPAP guidelines.
	• Debridement – not necessary to cover this.
	• Non debridement of heel ulcers is controversial.
	• Enzymatic and chemical debridement (are the same thing). It is not to be used as they are old techniques.
	• Autolytic debridement should be included.
	• Dressings – again not necessary to cover. Not known what resin salve is.
	• Pressure relieving devices – necessary to cover.

	• Nutritional intervention – very pleased for this to be covered. 4.3.1 d) Adjunctive therapies • No specific view but mentioned the addition of magnet therapy. 4.3.1e) Management of heel pressure ulcers • This should be included. <u>Group 2</u> 4.3.1 a) Risk assessment • The group felt the risk assessments need to be holistic, thus incl. environmental, manual handling, clinical judgment, patient reporting etc. assessment. In addition the group felt standard tools/scales are needed to ensure continuity of care. 4.3.1 b) Prevention a. The use of pressure relieving devices: • The group felt the use of the term 'reducing' was not necessary appropriate and the term 'relieving' or 'redistributing' the pressure was more accurate. In addition the group felt the list of devices was not exhaustive and all devices are important. b. Nutritional interventions: • The group felt that hydration was also an issue that needed to be explicitly mentioned in points regarding nutrition. c. Patient education • The group felt that the inclusion of carers and self management was needed in this point. • The group felt there was a need for a d. (Mobility, positioning and repositioning) and e. (Training for staff). 4.3.1 c) Management a. Ulcer assessment

	• The group felt that grading and classification were key to this point. b. Debridement • Some members of the group felt this was important, other felt this could be withdrawn from the scope. c. Dressings • The group felt that 'interactive, active and passive' dressings were important. They also thought antimicrobials were important. They had not heard of resin salve and so thought it could come out. e. Nutritional interventions • Again the group would like to see the addition of hydration to this point. • The group felt that an additional point 'management of symptoms, incl. pain' is needed. 4.3.1 d) Adjunctive therapies • Some members of the group felt the term 'adjunctive' was not appropriate and felt the term 'other' would be preferable. The group thought hydrotherapy could be excluded and that hyperbaric oxygen therapy may be expensive and not available in many places. The most important therapy for inclusion was topical negative pressure therapy (as this was widely used). The group was unsure about the inclusion of phototherapy and laser therapy. 4.3.1 e) Management of heel pressure ulcers • The group were pleased to see this point. • The group felt that two additional points were needed. One regarding the 'cleansing of pressure ulcers' and one regarding 'patient and carer education, including self assessment and self management. Clinical issues that will not be covered: • The group felt it should read 'management of venous and arterial ulcers'. • The group felt the inclusion of 'incontinence moisture lesion' and 'incontinence associative dermatitis' was needed.

	Healthcare settings
	• The group felt the transition between hospital settings and community settings needed to be a focus. Including transition from hospital to residential care (NHS and independent sector).
	
	<u>Group 3</u>
	• The group felt that the following areas should be included:
	  ○ Clothing
	  ○ Incontinence
	  ○ Repositioning / turning
	  ○ Neurological disorders
	  ○ Mental capacity act
	  ○ Skin assessment – including timing and staging of re-assessment
	  ○ Dietary/nutritional aspects and relevant chemical markers
	  ○ Hydration should be included alongside nutrition
	  ○ Training and education (mention of the Driver diagram, patient safety first)
	  ○ Pressure relieving devices should also include off loaders, bed rails, chairs and trolley mattresses.
	
	• The group felt that hydrotherapy should be included under 'debridement' as opposed to adjunctive therapies.
	• The group noted that there were areas of the previous two guidelines that were important and felt that there were a number of recommendations that should not be lost from the PRD guideline. There were some concerns about the new guideline replacing the existing guidelines.
	• The group felt that there were often difficulties in accessing adjunctive therapies as the centres are often a long distance away.
	
	<u>Group 4</u>
	Prevention and Risk assessment:
	• The section on risk assessment should consider the application of risk assessment tools, as well as 'using them'
	• Could include physiological measures

	• Add: and “skin assessment tools” • Add: “moving and handling” assessment • Add: “Nutritional device” assessment • Add: “assessment of the physical environment – e.g. device related” • Add: “perioperative warming” • Add: “Thermal imaging” • Add: “3D photography” • Relieving pressure is incorrect terminology – term should pressure redistributing (better) or pressure reducing. • Repositioning should be included – there is good evidence for this • Patient education should be amended to ‘patient/carer education’ • Staff training for preventative care should be included • Information on skin care should be included, with a cross reference to the continence guideline. • It is important to include something about recording risk assessment in the patient history. Management of pressure ulcers: • Ulcer assessment: does this refer to categorising pressure ulcers? There is evidence to suggest that clinicians do not do this well; therefore it might be better to recommend that this is not done. There should be a section on measurement of ulcers. • Assessment should be a separate area from management as it is necessary to assess something prior to managing it. • Currently there is nothing in here about reporting ulcers, which would be classed as a serious incident if a certain grade. • All areas included in prevention should continue to happen during the management phase. It would be beneficial to combine these for the scope. • Debridement: ’Ultrasound’ and ‘Hydrosurgical debridement’ should be included under this section. There is a NICE medical technology assessment on ‘MIST Therapy System’ • The scope should include pain assessment. • Dressings: there are several Cochrane reviews in this area. The terminology ‘passive/interactive/active’ is unclear and should be removed. Pressure relieving devices: • “Off-loading” and “anti-embolism stockings” should be included, with a cross reference to the VTE guideline. “Compression”, “re-positioning patients and devices (e.g. tubing)” and “warming” devices should also be

	included The list should be reordered to: Beds, mattresses, overlays, cushions, protectors, off-loading devices, and seating. • "Appropriate moving and handling" and "skin care" should be included. • The management of heel pressure ulcers does not need to be separated and can be included the in section on management of pressure ulcers. • "Magnetic therapy" should be included. • The use of "water-filled gloves" and "sheepskins" should also be included. • It is important to consider the issue that hospital mattresses are often too short. • Referral from anyone else to the specialist services can be a problem – it would be useful if the scope were to include something on transfer between services. Clinical issues that will not be covered • There was a comment that venous leg ulcers are distinct from pressure ulcers. • 'All other wounds' should also be excluded. This would include e.g., moisture lesions. <u>Group 5</u> • The group felt that it was important to include recommendations on how to distinguish between a diabetic foot ulcer and a foot pressure ulcer, as there were financial and safety ramifications to getting this wrong. Risk assessment • The group noted that it would be useful to look at tools in primary care/community as these were underutilised • The guideline should look at education on the use of tool as part of a wider holistic assessment of risk • Any section on tools should include a recommendation on skin inspection and self assessment • It was noted that there was a lack of clarity surrounding who had responsibility for risk assessment, prevention etc of pressure ulcers and the guideline could clarify this issue • The scope should look at patient/carer education/training, rather than just patient education/training • The scope should cover mandatory training for healthcare professionals, particularly nursing staff

	and senior care workers • The group noted that assessment of continence was an important issue to consider Prevention • The group felt that the use of telemedicine should be considered in the guideline as this was increasingly used by people in the community (e.g., to text pictures of ulcers) • The group felt that timing of intervention was an important thing for the guideline to consider • The group agreed that seating should be considered and acknowledged that seating was a particular issue for bariatric patients • The group felt that the most important aspect for inclusion was positioning/repositioning and mobility • The group felt that prevention was crucial and the most important area. Management • The group felt that the most important aspect for inclusion was positioning/repositioning and mobility • The group felt that topical negative pressure should be considered but should be considered as a topical agent as opposed to an adjunctive therapy • The group felt strongly that surgical intervention should be considered as this is an increasingly used management technique • The group felt that there should be a recommendation on how to treat patients for whom no management strategy has proved successful • The group felt that there should be a recommendation on how to treat patients who were unwilling to adhere to prevention and management methods • The group requested that the guideline included a recommendation on when to refer a patient to a tissue viability nurse Adjunctive therapies • The group noted that topical negative pressure therapy, electrotherapy and hyperbaric oxygen therapy were the most important therapies for consideration. It was agreed that there were often

	difficulties in accessing these therapies and evidence was sometimes limited. • The group noted that hydrotherapy was not widely used. Heels • It was agreed that this was important as this is a big issue in the community and is increasing in prevalence. <u>Group 6</u> • The group felt that pain management should be included for both prevention and management. For example, if a patient has a pressure ulcer, they will be likely to be suffering from pain at that site – it is important to treat the pain. Some dressings can help to treat this but should be used alongside pain medications. Risk assessment • The group felt that risk assessment tools and scales are not particularly useful. It would be more helpful to look at the risk factors to consider when assessing risk, most notably mobility and skin assessment. A member of the group is shortly to publish a systematic review on this area. Prevention • The group felt that skin moisture and pain management should be included, as both issues relate to prevention and need to be followed up. • The group agreed that repositioning/turning should be included in the section on prevention. • The group agreed that skin assessment should be included in the section on prevention. Management • Pain management should be included, as well as addressing the potential risk factors for pressure ulcers. • There were some queries regarding resin salve. No one in the group knew what resin salve was. • The group felt that skin flaps need to be included. This work is usually carried out by a plastic surgeon. The group noted that skin flaps were mentioned in section 3.2 on “Current Practice” but

	not as an intervention to be considered. Adjunctive therapies • The group felt that topical negative wound pressure therapy has become mainstream treatment and no longer an adjunctive therapy. It should be moved to the section on management. • The group noted that none of the adjunctive therapies noted in this section were typically used to treat pressure ulcers. Heel ulcers • The group questioned the reasoning behind looking at heel pressure ulcers separately. <u>Group 7</u> Prevention • The group noted that there were a number of examples of prevention strategies available, for example, 'Skin bundle' (a communication strategy for pressure ulcer prevention) and the NPSA led 'Safety Express' initiative. It was suggested that a second bullet point be added under "risk assessment, labelled "protocols/strategies" • It was noted that education and training for people with sensory impairment was important. Management • The group agreed that it would be useful to clarify the issue of grading pressure ulcers, as well as the correct tool to use. The group felt that the term 'level' of risk required defining on a national basis. • Rewording of "ulcer assessment" suggested as unclear this meant the grading of an existing pressure ulcer. • The group agreed that currently the definitions of pressure ulcers are misleading. A separate section on defining a pressure ulcer would be helpful given that ulcers of a certain grade and above often must be declared as clinical incidents. • It was noted that 'nutritional interventions as preventatives strategies for individuals with and without nutritional deficiency' should be changed to 'nutritional interventions' in the management section as the group stated that everyone with a PU must be nutritionally deficient by definition.

Specific probes for key clinical issues:
• **Devices**
• **Dressings**
 	
• **Interventions**
	<u>Group 1</u>
	• The group felt that dressings are often over emphasised and is not the most important area of management. It is driven by cost and evidence.
	• The group felt that devices have a large impact and cost effectiveness is very important.
	
	<u>Group 2</u>
	• All devices are important.
	• The most important dressings to consider are interactive, active and passive dressings. The group had not heard of resin salve. It is important to include antimicrobials.
	
	<u>Group 3</u>
	• The group discussed devices. It was agreed that the most important aspects of devices were:
	  ○ Ultra sound
	  ○ Off loaders
	  ○ End of foot beds
	  ○ Bed rails
	  ○ Trolley mattresses/Scanner mattresses
	• The group discussed dressings. They group were not familiar with the use of resin salve and questioned whether this was used in the UK. It was noted that there needed to be some clarification as to what was a 'passive' dressing and the other terms. The group concluded that this is an area that could be excluded from the scope as it is not specific to pressure ulcers.
	
	<u>Group 4</u>
	None
	
	<u>Group 5</u>
	• The group agreed that devices should include seating. The group noted that there are often problems with accessing and obtaining devices in a timely manner. Many devices are not used on the correct individuals, creating supply issues for those individuals who do need these devices.

	• The group felt that dressings were an important area however, their importance is often over emphasised. It was agreed that other aspects of prevention, assessment and general wound care were more important. However the group noted that, if dressings were included, the most important to consider are antimicrobials (including honey, iodine and silver). <u>Group 6</u> • The group discussed dressings and noted that there was a Cochrane review in this area; however, the group were unsure whether this was specifically based on pressure ulcers. There were some queries about the quality of evidence available in this area. The group noted that there was no general consensus on the dressings to use, although silver dressings were often used in infection. <u>Group 7</u> • The group discussed devices. Suggested adding "chairs" to the list of devices. The group felt strongly that devices should be used as an aid or tool in prevention of PU, but the most important of prevention was nurse time and repositioning. • The group discussed dressings. It was agreed that it would be useful to have a general wound management guideline as these were interventions that were useful for all wounds, not specific for pressure ulcers. The group wanted to move away from pressure ulcers being seen as different to other wounds and agreed that the guideline should only cover debridement, dressings, devices and adjunctive therapies in relation to heel pressure ulcers which could be seen as different to other wounds. • The group felt the most important areas to cover were risk assessment and ulcer grading.
Further Questions:	
1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?	
<u>Group 1</u> • Faecal management systems and positioning. <u>Group 2</u> • See above <u>Group 3</u> It was felt that the following critical issues had been missed: • Staffing levels	

- People in long term care
- Expertise and training of staff

Group 4

- None

Group 5

- The group felt that the use of support surfaces in x-ray and surgical situations should be considered as there was poor provision in these areas.

Group 6

- The group felt that repositioning was the important factor for prevention, alongside skin care and treatment.

Group 7

The group felt that the following critical issues had been missed:

- The group noted that it would be useful to include a question on referral (e.g., to dermatology, plastics). The group also mentioned self referral of a patient into the care pathway following self management/recognition of early symptoms.
- It was noted that patient education in the prevention of pressure ulcers should be included in the scope.
- It was agreed that the section of the scope on 'Risk assessment' should include safeguarding adults at risk.
- It was agreed that the management section of the guideline should include the importance of local reporting structures and emphasise the use of a multidisciplinary team.
- The group noted that repositioning had not been included in the scope and that it should be considered, along with positioning and frequency of repositioning in the scope.
- The group agreed that management of pain should be included.

2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?

Group 1

- No

Group 2

- See above

Group 3

- Dressings

Group 4

- None

Group 5

- None

Group 6

- None

Group 7

- Aspects of wound management except in relation to heel pressure ulcers (as noted above)

3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?

Group 1

- The use of donuts – this is poor practice and should be addressed.

Group 2

- Grading and classification of pressure ulcers

Group 3

- Training and education

Group 4

- None

Group 5

- The group agreed that there was diverse practice in the use of dressings.
- The group felt that the use of water filled gloves was poor practice

Group 6

- None

Group 7

- The group felt that it should be a registered nurse that carried out risk assessments as opposed to a healthcare assistant, as it was the registered nurses who were accountable for the ulcers. The group felt it would be useful to include a recommendation relating to competencies and training for nurses.
- The group felt that anyone at high risk of developing pressure ulcers should be subject to regular, daily skin assessments.
- The group would like to see clearer definitions in relation to risk (i.e. what does mild/moderate/severe mean in practice?)

4. Which area of the scope is likely to have the most marked or biggest health implications for patients?

Group 1

- Prevention

Group 2

- Grading and classification of pressure ulcers

Group 3

- None

Group 4

- None

Group 5

- None

Group 6

- The group agreed that prevention would save the NHS the biggest amount of money. NHS Trusts are fined if patients develop pressure ulcers. The group thought that nursing time also contributed the biggest cost to pressure ulcer treatment/prevention. It was stated that some economic studies tended to discount the importance and costs of nursing time as a resource item. The group also discussed that studies to inform an economic analysis may be of poor quality and the sample sizes may be small.

Group 7

- Repositioning times. Repositioning frequency. 30^{o} tilt positioning/repositioning (and frequency). Pain (as a precursor to ulcer development) and pain management

5. Which practices will have the most marked/**biggest cost** implications for the NHS?

Group 1

- Nursing time is very important and an area that needs to be evaluated for cost effectiveness.
- Repositioning and nutrition.

Group 2

- Pressure relieving and redistributing devices.
- Time to position and reposition
- Adverse events.

Group 3

- Failure to treat
- Prolonged bedstay
- Equipment
- Staff time
- Adjunctive therapies – versa jet may have a high cost but may prevent theatre and additional expenses.
- The group also felt that the portable negative pressure devices (e.g, PICO) and debridement methods could have an impact on cost.

Group 4

- Equipment has the biggest cost and this is not always used appropriately. It is important that healthcare staff ensure that there is stepping up and

stepping down use of equipment. It is important that the right equipment is used on the right patient – this is down to education.

Group 5

- None

Group 6

- None

Group 7

- Repositioning

6. Are there any **new practices** that might **save the NHS money** compared to existing practice?

Group 1

- Using a 30 degree tilt more
- 'Comfort round' which includes 2 hour turning.

Group 2

- None

Group 3

- The group agreed that prevention had the biggest saving implications for the NHS.

Group 4

- None

Group 5

- The group felt that devices may have the biggest cost implications for the NHS as these are often given to the wrong patients. The group also agreed that devices that were single use were particularly expensive – this is the case with devices used for the management of heel ulcers.

Group 6

- None

Group 7

- Emphasis on repositioning and nursing time over use of devices

7. If you had to delete (or de prioritise) two areas from the Scope what would they be?

Group 1

- Dressings
- Therapies (variation in access and budget)
- Devices.

Group 2

- None

Group 3

- Dressings - all other areas important

Group 4

- It might be possible to remove dressings.

Group 5

- Dressings

Group 6

- None

Group 7

- The group suggested that dressings, debridement, and adjunctive therapies were the most appropriate areas to be deprioritised from the scope. However, these would be important areas to consider with regards to the management of heel pressure ulcers.

8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?

Group 1

- Prevention, risk assessment, definition of pressure ulcers and differential diagnosis, patient empowerment, re-positioning, nutrition.

Group 2

- None

Group 3

- The group felt strongly that turning, positioning/repositioning was more important that the use of devices and that training was important. However, the key 3 clinical areas were agreed as:
    1. Prevention and training
    2. Dressings (as an area for exclusion)
    3. Grading/Risk assessment
- Prevention and risk assessment the most important but felt all of the other areas bar dressings should be included (unless the previous PRD guideline is used in some way).

Group 4

- None

Group 5

The key three clinical areas were agreed as:

1. Prevention/education
2. Devices
3. Risk assessment

Group 6

- Repositioning/turning
- Skin care
- Pain management
- Dressings
- Mattresses, overlays and cushions

Group 7

- The group agreed that the most importance issues are: assessment, grading and interventions relating to heel pressure ulcers

9. What are the top 5 outcomes?

Group 1

- None

Group 2

- 4.4 c) & e) Remove and replace research terms. 'Patients' instead of participants and remove 'trial'.
- 4.4 c) The group said that it depended on avoidable or unavoidable pressure ulcers and this should be defined in the glossary.
- 4.4 d) The most important outcome was whether the patient had healed or not healed.
- 4.4 f) The group felt this could be withdrawn from the scope as it is measurable but not useful.

Group 3

- The most important outcomes were quality of life and improvement/change in wound

Group 4

Definitions should be included here. Add: Key definition including avoidable / unavoidable, how to calculate rates and how to report pressure ulcers.

- "Rate of change in ulcer area/volume" should be reconsidered. This can be misleading as some ulcers increase in size/volume as they heal. A more appropriate term would be 'Change in status'.

- The following outcomes should be included: “mortality”, “morbidity”, “length of stay”, “recurrence, prevention of deterioration” and “improvement in symptoms”.

Group 5

The group felt that the following outcomes should be included:

- Quality of life
- Mortality
- Restriction of lifestyle

Group 6

- The group felt that the term ‘adverse events’ should be more descriptive because pressure ulcers themselves are often seen as the adverse event.
- The group felt that infection should be included as an outcome.
- The group felt that measurements of health-related quality of life may be confounded by the nature of the primary disease and not the issue of pressure ulcers themselves. The available instruments for measuring health-related quality of life may not be sensitive to pressure ulcers.
- As an outcome for prevention, the group felt that the wording “Proportion of participants developing new pressure ulcers” should be amended to “Proportion of people who do not develop new pressure ulcers”
- The group considered the following outcomes as their top 5 outcomes:
    - Prevention of pressure ulcers
    - Prevention of the development of severe pressure ulcers
    - Rates of healing without complications
    - Health-related quality of life
    - Adverse events
- The group discussed that the need for surgery/debridement and mortality are relevant outcomes to be considered.

Group 7

- Pain should be added to the list of outcomes. The group also suggested adding delayed discharge from hospital due to a pressure ulcer (which may have economic implications)

10. Any comments on GDG membership?

Group 1

- Must be tissue viability nurse (not a wound care nurse), co-opt patient safety/ safeguarding expert.

Group 2

- Wound care nurses are not appropriate for this guideline, tissue viability nurses are best placed to contribute.

Group 3

- The group felt that the following people should be included in the GDG:
    - Nurses should also cover mental health
    - Equipment specialist nurse / medical devices person
    - Podiatrist (full member)
    - Plastic surgeon (co-optee)
    - Healthcare assistant support worker
    - Occupational therapist (co-optee)
    - Dietician (co-optee) or could be a nutrition nurse specialist
    - Midwife (co-optee)

Group 4

- The Guideline Development Group should include tissue viability specialists rather than wound care specialists. These should be individuals based in primary care, special care and mental health/learning problems.
- An individual who specialises in moving and handling should also be included.
- The group should recruit only 1 paediatric tissue viability nurse and increase the number of adult nurses.
- It is important to include a specialist occupational therapist.
- A medical illustrator might be a useful member of the group.

Group 5

The group felt that the following people should be included on the GDG:

- Seating expert (may be an occupational therapist)/someone from wheelchair services
- 1 tissue viability nurse from community/primary care
- 1 tissue viability nurse from secondary care
- A continence nurse
- 1 paediatric tissue viability nurse from primary, community or secondary care

- The group did not feel that a GP was needed on the GDG.

Group 6

- The group felt that the GDG membership contained too many doctors and that more nurses should be recruited. The group did not agree that a GP was needed on the GDG, as GPs rarely treat pressure ulcers.

The following members should also be included on the GDG:

- Dietician (co-optee)
- Nurse/GP commissioner
- Occupation therapist (with responsibility for seating & wheelchairs)
- Acute nurse (specialist)
- Paediatric nurse (specialist)
- Community nurse (specialist)
- Academic or educationalist
- Surgeon (co-optee)

- It was mentioned that a GP commissioner should be considered for the GDG membership.

Group 7

- The group should include an equipment specialist and a manual handling advisor. The group noted that the prevention and management strategies would be the same across all age groups except neonates due to differences in skin and site of ulcers. If neonates were to be included then views of a neonatal specialist should be sought.

11. This guideline will eventually help to inform a quality standard on pressure ulcers. Are there any areas that you think should be included for the purposes of the quality standard? Are there any service delivery or service configuration issues that you think are important?

Group 1

- Prevention needs to be included within management.

Group 2

- None

Group 3

- None

Group 4

- There is often a problem referring patients with pressure ulcers to specialist services. Additionally, there is often an issue with the maintenance of pressure relieving devices.

Group 5

- None

Group 6

- None

Group 7

- Risk assessment and grading by a registered nurse. Adequate staff training for risk assessment and grading. Multidisciplinary team.

12. Other issues raised during subgroup discussion for noting:

Group 1

- CQC report on PU due this week.
- TVS working on national consensus
- No national benchmarking
- Not to throw away the old guideline
- How is the guideline going to link into safeguarding?
- Compliance is a large issue and is a very significant factor
- The focus needs to move away from equipment and move to care; assessment and re assessment.

Group 2

- They thought there was a lack of social care in the community, nursing home patients have care 24/7 but if at home they are seen twice a day and so they are not changing position as often.

Group 3

- The group noted that it was important that the terminology was amended throughout the scope so that there was consistency in use of the phrase 'pressure sores'.

Group 4

The key messages discussed by the group were as follows:

- Definitions are very important to this guideline as there is no consistency across the country, including avoidable / unavoidable, how to calculate rates and how to report
- Changing how to articulate the assessment and how you apply risk assessment tools, rather than how you used them.

- It might be useful to include physiological measures, skin assessment tools, moving and handling assessment, nutritional device assessment, assessment of the physical environment (in relation to devices), perioperative warming, thermal imaging and 3D photography.
- The education of staff is important. It is important that the right equipment is used for the right patients and that there is appropriate training for staff on preventative care.

General comments regarding definitions and terminology:

- The definition of pressure ulcer needs clarification to distinguish between what is an 'avoidable pressure ulcer' and what is an 'unavoidable pressure ulcer'. Further guidance is also need about how to count pressure ulcers.
- Friction and moisture are outdated terms.

Group 5

- The group noted that the James Lind Alliance was currently reviewing and analysing evidence relating to pressure ulcers.

Group 6

- The group discussed the definition of pressure ulcers in section 3.1 of the scope and noted that this should reflect the definitions of pressure ulcers as presented in the EPUAP-NPUAP (European Pressure Ulcer Advisory Panel-National Pressure Ulcer Advisory Panel) 2009 guidelines.
- The group agreed that the section on epidemiology needed further definition on what was meant by 'primary care'. The group noted that the figure quoted in section 3.1 of the scope for new pressure ulcers (4-10%) is based on a single study cohort in the 1990s. It was felt that there may be more up to date references available on the incidence of new pressure ulcers; for e.g., there is a systematic review by Kaltenhalter published in 2001.
- The group also felt that there should be information on pain provided in the epidemiology section.
- The group felt that the title should be amended to include all areas of care highlighted in the presentation given by NCGC.
- The group felt that Section 3.2 on 'Current Practice' should include information on skin care.

Group 7

- Chairs are not listed in the interventions.
- Nursing/care homes were purchasing the wrong types of mattress.
- The group discussed the possibility of there being specific issues in end of life care and neonatal care.