Pressure ulcers and incontinence-associated dermatitis: effectiveness of the Pressure Ulcer Classification education tool on classification by nurses

Dimitri Beeckman,1,2 Lisette Schoonhoven,3 Jacqui Fletcher,4 Katia Furtado,5 Hilde Heyman,6,7 Louis Paquay,8,9 Dirk De Bacquer,1 Tom Defloor1

ABSTRACT

Context Previous studies report that pressure ulcer classification and differentiation from incontinence associated dermatitis is difficult. Incorrect classification and differentiation result in incorrect prevention and treatment. Education is important to spread evidence-based insights about this topic and to improve classification skills.

Aim To assess the effectiveness of the Pressure Ulcer Classification (PUCLAS) education tool. PUCLAS was developed by the PUCLAS Workgroup of the European Pressure Ulcer Advisory Panel.

Design Randomised controlled trial.

Setting and participants A convenience sample of 1217 Belgian, Dutch, British and Portuguese nurses.

Outcome measure Correct classification of pressure ulcer photographs and differentiation from photographs of incontinence-associated dermatitis.

Results Baseline, 44.5% of the photographs were classified correctly. In the post-test, the results in the intervention group were significantly higher (63.2%) compared with the control group (53.1%; p<0.001). The percentage of correct assessments of incontinence associated dermatitis (IAD) was 70.7% in the intervention group and 35.6% in the control group (p<0.001). The skill to differentiate IAD from pressure ulcers was significantly associated with the experimental intervention (OR 4.07, 95% CI 3.21 to 5.15, p<0.001).

Conclusion The PUCLAS tool improved pressure ulcer classification and IAD differentiation significantly.

INTRODUCTION

Pressure ulcers are complex lesions of the skin and underlying structures caused by prolonged pressure on the tissues or by shearing forces.1 2 Pressure ulcers are a major burden in terms of patient suffering, mortality, morbidity, rehabilitation and healthcare expenditures.3–6 Decreased health and restricted mobility make hospitalised patients and nursing home residents particularly vulnerable.7

Pressure ulcers are an internationally recognised patient safety problem and are often preventable. Despite the increasing expenditure on prevention, pressure ulcers remain a major healthcare problem.5–10 In 2002, prevalence in European hospitals was 18.1%. Only 10% of the patients in need of prevention received adequate prevention.5 Pressure ulcer prevention is a responsibility of all healthcare professionals involved in patient care.11

Classification systems are accepted standards to determine pressure ulcer severity.12 Recent studies showed that pressure ulcer classification is difficult13–18 and that misclassification between pressure ulcers and incontinence-associated dermatitis (IAD) frequently occurs.14 15 19 IAD is an inflammation of the skin that occurs when urine or faeces comes into contact with perineal or perigenital skin. The lesions are characterised by erosion of the epidermis and a macerated appearance of the skin.20 Differential diagnosis between pressure ulcers and IAD is based on visual examination.21–23 Misclassification has significant implications for prevention, treatment, and reporting and benchmarking on quality of care.

Classification skills are likely to benefit from education. No research reporting the effectiveness of education on classification skills could be found. This study aims to evaluate the effectiveness of the Pressure Ulcer Classification (PUCLAS) education tool on classification skills by nurses.

METHODS

Study design and study population

A randomised controlled trial design was used. A convenience sample of 1217 nurses from Belgium, The Netherlands, UK and Portugal participated. Data were collected between September 2005 and December 2006. Nurses attending a wound care conference were approached to participate in the study. Before data collection, the purpose and procedure were explained, and anonymity and confidentiality were ensured. The study was approved by the ethics review committee of Ghent University Hospital. The ethics committee waived the need for written informed consent. A completed questionnaire was taken as consent to participate.

Operational definitions

European Pressure Ulcer Advisory Panel classification system

The European Pressure Ulcer Advisory Panel (EPUAP) classifies pressure ulcers in four grades based on the severity of the lesion. This European classification system is widely used for application in research, teaching and patient care (table 1).24

PUCLAS education tool

PUCLAS is a tool to teach and learn about pressure ulcer classification and IAD differentiation, and was developed by the PUCLAS Workgroup of the...
Table 1  European Pressure Ulcer Advisory Panel classification system

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>Non-blanchable erythema of intact skin. Discoloration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly in individuals with darker skin.</td>
</tr>
<tr>
<td>Grade 2</td>
<td>Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.</td>
</tr>
<tr>
<td>Grade 3</td>
<td>Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.</td>
</tr>
<tr>
<td>Grade 4</td>
<td>Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.</td>
</tr>
</tbody>
</table>

EPUAP. It is based on the EPUAP position statement on pressure ulcer classification and IAD differentiation, and provides an overview of causative factors and of typical wound-related characteristics including location, shape, depth, necrosis, edges and colour (table 2).

Table 2  Synthesis of the European Pressure Ulcer Advisory Panel position statement on pressure ulcer classification and incontinence-associated dermatitis (IAD) differentiation

<table>
<thead>
<tr>
<th>Pressure ulcer</th>
<th>IAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cause</td>
<td>Moisture must be present (eg, shining, wet skin caused by urinary incontinence or diarrhoea).</td>
</tr>
<tr>
<td>Location</td>
<td>IAD may occur over a bony prominence; however, pressure and shear should be excluded as causes, and moisture should be present.</td>
</tr>
<tr>
<td>Shape</td>
<td>Diffuse, different superficial spots are more likely to be IAD.</td>
</tr>
<tr>
<td>Depth</td>
<td>Superficial (partial thickness skin loss).</td>
</tr>
<tr>
<td>Necrosis</td>
<td>No necrosis.</td>
</tr>
<tr>
<td>Edges</td>
<td>Diffuse or irregular edges.</td>
</tr>
<tr>
<td>Colour</td>
<td>Blancheable or non-blancheable erythema; pink or white surrounding skin due to maceration.</td>
</tr>
</tbody>
</table>
Table 3 Characteristics of study nurses

<table>
<thead>
<tr>
<th>Category</th>
<th>Intervention (n=658), percentage (%)</th>
<th>Control (n=559), percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (percentage male)</td>
<td>13.5 (87/643)</td>
<td>12.2 (68/558)</td>
</tr>
<tr>
<td>Expertise (percentage expert)</td>
<td>35.1 (224/639)</td>
<td>30.0 (163/544)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undergraduate</td>
<td>45.7 (300/655)</td>
<td>58.3 (326/559)</td>
</tr>
<tr>
<td>Bachelor</td>
<td>48.9 (321/655)</td>
<td>36.5 (204/559)</td>
</tr>
<tr>
<td>Master</td>
<td>5.2 (34/655)</td>
<td>5.2 (29/559)</td>
</tr>
<tr>
<td>Age category (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>5.8 (38/658)</td>
<td>12.2 (68/559)</td>
</tr>
<tr>
<td>25–35</td>
<td>27.4 (180/658)</td>
<td>24.2 (135/559)</td>
</tr>
<tr>
<td>35–44</td>
<td>37.1 (244/658)</td>
<td>32.6 (182/559)</td>
</tr>
<tr>
<td>&gt;44</td>
<td>29.8 (196/658)</td>
<td>31.1 (174/559)</td>
</tr>
<tr>
<td>Work experience (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>13.1 (86/658)</td>
<td>18.8 (103/548)</td>
</tr>
<tr>
<td>5–10</td>
<td>14.4 (95/658)</td>
<td>17.5 (96/548)</td>
</tr>
<tr>
<td>10–20</td>
<td>40.9 (269/658)</td>
<td>34.9 (191/548)</td>
</tr>
<tr>
<td>&gt;20</td>
<td>31.6 (208/658)</td>
<td>28.8 (158/548)</td>
</tr>
<tr>
<td>Country</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belgium</td>
<td>60.6 (399/658)</td>
<td>26.7 (149/559)</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>15.3 (101/658)</td>
<td>55.3 (309/559)</td>
</tr>
<tr>
<td>Portugal</td>
<td>4.6 (30/658)</td>
<td>3.0 (17/559)</td>
</tr>
<tr>
<td>UK</td>
<td>19.5 (128/658)</td>
<td>15.0 (84/559)</td>
</tr>
</tbody>
</table>

DISCUSSION

Before training, the classification skills of the study nurses were poor. Pressure ulcers and IAD were frequently classified incorrectly. After reviewing the EPUAP classification system, limited improvement was seen in the observation of IAD. Attending PUCLAS resulted in significantly more correct observations of IAD compared with the control group.

Based on this study, we can assume that the description of clinical guidelines about the differential diagnosis between pressure ulcers and IAD provided a positive effect. The effectiveness was probably supported by the use of clear definitions, descriptions and exercises. The theoretical insights were depicted unambiguously and, where suitable, graphically supported.

Ethical, legal and financial implications mean that a correct differentiation between pressure ulcers and IAD is important. Incorrect differentiation results in inadequate preventive and therapeutic measures, and in suboptimal use of available resources. Prevention of IAD comprises a structured skin care regimen including gentle cleansing, moisturisation and application of a skin protectant or moisture barrier. Treatment goals include protecting the skin from further exposure to irritants, establishing a healing environment and eradicating cutaneous infection.20–21 Contrarily, prevention of pressure ulcers comprises a reduction in the intensity and/or duration of pressure and shearing forces on the tissue. Pressure-relieving mattresses, cushions and postures are some of the possibilities that can be used.25

Correct classification of pressure ulcers and differentiation between IAD requires a profound knowledge and clear understanding of the different skin layers, physiology and pathology of the skin. Care givers should be trained prior to undertaking pressure ulcer classification. Tissue viability training and unambiguous observation guidelines are important and should be presented at an appropriate level to maximise retention and to ensure an adequate adoption of skills in daily practice.

PUCLAS is developed for both clinical basic and in-service education. The programme can be used as a stand-alone teaching module, as an e-learning module or as a supporting online educational package for blended learning. PUCLAS can easily be implemented by healthcare organisations (hospitals, nursing homes, home care) to teach staff about pressure ulcer classification and IAD differentiation. It is important to note that this knowledge will probably not be static and that PUCLAS should be regularly presented. More research is needed to evaluate whether better classification skills and skills to differentiate between pressure ulcers and IAD would improve preventive care of pressure ulcers and IAD.

The identification of non-blanchable erythema seemed to remain difficult. Accurate identification of non-blanchable erythema (grade 1) is important in pressure ulcer prevention. Research shows that non-blanching erythema with or without other skin changes differs from normal skin/blanching erythema and is associated with a higher risk for pressure ulcer development.26 27 Confusion about a grade 1 pressure ulcer will probably result in a delayed application of preventive measures and subsequently pressure ulcer development. Recent research showed that using non-blanchable erythema as an indicator to start prevention led to a considerable reduction in patients in need of prevention without an increase in pressure ulcers.28 In this study, the confusion about non-blanchable erythema might be caused by the use of photographs providing only a two-dimensional view of the lesion. As a result, the dynamic process of blanching erythema could not be presented fully.

An alternative for the use of photographs could be skin assessment in clinical practice. Whether skin assessment in clinical practice is easier than using photographs is unknown. Skin assessment in clinical practice will cost more time and will be more small-scale and harder to organise. Ethical issues should also be considered. Photographs, combined with information about the medical and wound history of the patient, his mobility, incontinency status and nutritional condition might be more effective. Cases including photographs or video material could be an alternative and should be a subject for further research.

Pressure ulcer classification improved in both the intervention and the control group, but did not become optimal. After the intervention, pressure ulcer classification remained difficult. Based on this study, we suggest that the complexity of the four-grade EPUAP classification system should be evaluated. It could be questioned whether it is important to classify pressure ulcers in four grades. Each grade indicates the degree of tissue damage, but provided limited indication (depth) for treatment and evaluation. An alternative could be to switch to a less complex classification system. This new classification should make a distinction between healthy skin, non-blanchable erythema and a pressure ulcer. The distinction between pressure ulcers and IAD is more important for determining a correct therapy than being able to classify pressure ulcers in different grades.
Lack of knowledge among nurses related to differentiating stages of pressure ulcers has previously been reported (Blanchard et al. 2006; Defloor et al. 2004). This study aimed to determine whether an educational intervention can improve nurses’ diagnostic skill using photographs. An educational intervention involving a five-minute PowerPoint presentation was compared to a control group who received no intervention. Different photographs were used for paired comparison. The intervention group’s diagnosis skill improved significantly when comparing with pre-test (p<0.0001). The results indicated that nurses’ diagnostic skill improved significantly when using photographs. The educational intervention was found to be effective in improving nurses’ diagnostic skill. The study findings can be used to develop strategies for pressure ulcer prevention and treatment.

**Limitations**

The study relied on nurses attending a wound care conference, which may introduce bias into the results. The study also did not compare the diagnostic skill of nurses who did not attend the conference.

**Conclusion**

The study findings provide evidence for the effectiveness of educational interventions in improving nurses’ diagnostic skill. The results can be used to develop strategies for pressure ulcer prevention and treatment.

**References**

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