

A wound classification *lingua franca?*



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In attending the 2010 Edinburgh Diabetic Foot Journal Conference, I was one of the minority 10% of nurses on the delegate list. One interesting exercise at that event was an interactive session on the classification of foot lesions using the University of Texas (UT) system (Lavery et al, 1996), which is specific to diabetic foot wounds. A short time before the conference, I was involved in a similar group exercise classifying pressure ulcers using the European Pressure Ulcer Advisory Panel (EPUAP) classification system (Defloor and Schoonhoven, 2004), which (as the name suggests) classifies the severity of pressure ulcers.

Background

All classification systems – the EPUAP and UT being no exception – require the clinician to identify a range of clinical characteristics, the specific combination of which place the wound in one or another sub-set. Classification using a validated tool should influence treatment plans, predict outcomes, provide auditable information that informs future resource allocation and, ultimately, improve patient outcomes.

The EPUAP and the UT have both found widespread acceptance, although perhaps not in the same professional circles. It struck me that a nurse assessing a diabetic heel lesion would probably classify the wound using the EPUAP, rather than the UT – while the reverse would be true of a podiatrist. Thus, the professional's background – rather than the patient and their foot – may determine the method of wound classification and this

has implications for both clinical practice and patient outcomes.

Are we in danger of comparing apples with *pommes* – same wound, different language? Most concerning, will our patients experience poorer care or worse outcomes as a result of inter-professional mistranslations?

Apples with apples?

Pressure ulcers and diabetic foot lesions have much in common. Both occur in people with increased comorbidities and, in general, are frequently complicated by infection, vascular insufficiency and occur over bony prominences. Pressure, friction and shear forces are the extrinsic causes of damage in both cases – albeit, in general, one occurs in your patient's shoe, the other in their seat or bed. Both require a timely and holistic multidisciplinary response, the central principles of which are attention to offloading, wound-bed preparation, debridement, revascularisation and infection control.

With so much in common, does not the use of either the EPUAP or the UT seem justifiable when assessing a person with diabetes and a foot ulcer?

... by any other name

Consider a person with diabetes – either in hospital or the community – who has developed a foot lesion, classified as EPUAP grade 2; Partial thickness loss of dermis presenting as a shallow open ulcer with a red–pink wound bed, without slough (EPUAP and National Pressure Ulcer Advisory Panel, 2009). While

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the EPUAP grade would suggest that wound is a UT grade 1, it would not be clear whether this was 1A, or whether the meaningful caviates of infection (IB), ischaemia (1C), or both (1D) were in play. It could be argued, therefore, that the EPUAP classification is not specific enough to reflect the severity of the diabetic foot lesion and may, in turn, fail to result in a comprehensive, individualised care plan or the timely involvement of the multidisciplinary foot team.

Talking among ourselves

When using a wound classification tool in the clinical setting, it is essential that all those involved in the care of the person with the wound understand the classification and can ensure that best practice care planning for that wound type is flowing from the correct assessment of the wound and patient. Yet, as members of professional groups, we all develop our own language and areas of expertise that set us apart from others and this includes classification tools. When the political or economic climate becomes challenging, we become still more insular to protect our identity and specialism.

While there is a case for becoming “professional bilingual” with regard to wound classification systems, with it comes the danger that relevant information will be lost in translation; the EPUAP and UT are not designed or validated to correspond to each other.

Yet, it is a challenge to expect clinicians to apply the EPUAP to pressure ulcers in general, but use the UT in particular if the pressure ulcer in question sits on the foot of a person with diabetes. Governance issues are also relevant; people who have developed pressure ulcers, whether they have diabetes or not, must be included in prevalence and incidence reporting for pressure ulcers with EPUAP classification. Thus, those individuals with diabetes and a pressure ulcer of the foot will appear in audit data as both a person with an EPUAP-classified pressure ulcer, and a person with UT-classified diabetic foot ulceration. This duplication of effort means one clinician providing two sets of wound classification data, or two clinicians reporting different data on the same wound.

Conclusion

The use of a validated wound classification system should be viewed as an integral part of patient assessment and clinical management planning, and the UT has emerged as the front-runner in diabetic foot care. However, there is a need to ensure that all healthcare professionals are fluent in using and reading the UT to ensure it effectively feeds into care planning, reporting, timely referrals and so on. Without inter-professional fluency in the UT, this important tool may represent a barrier to effective multidisciplinary working and positive patient outcomes. ■

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Lavery LA, Armstrong DG, Harkless LB (1996) Classification of diabetic foot wounds. *J Foot Ankle Surg* 35: 528–31