THE NATIONAL QUALITY FORUM

NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR DEVELOPING A FRAMEWORK FOR MEASURING QUALITY FOR PREVENTION AND MANAGEMENT OF PRESSURE ULCERS
MEETING OF THE STEERING COMMITTEE

January 6-7, 2009

A two-day meeting of the Developing a Framework for Measuring Quality for Prevention and Management of Pressure Ulcers Steering Committee took place on January 6 and 7, 2009, at the Marriott at Metro Center in Washington, DC.

***Panel members present*:** Ben Peirce, RN, CWOCN, COS-C (Co-Chair); Debra Saliba, MD, MPH (Co-Chair); Sandra Bergquist-Beringer, RN, PhD, CWCN; Dan Berlowitz, MD; Margaret Birdsong, CRNP; Lynn Carpenter Moore, RD, LD; Katherine Chick, RN, MSN, CNS; Jean DeLeon, MD; Theresa Edelstein, MPH, LNHA; Caroline Fife, MD; Mary Hagle, PhD, RN, AOCN; Courtney Lyder, NG, GNP, FAAN; Jeanine Maguire, PT; Catherine Ratliff, PhD, APRN-BC, CWOCN; David Smith, MHSA; George Taler, MD; Donald Thomas, PhD; Nancy Tomaselli, RN, MSN, CS, CRNP, CWOCN, CLNC; William Wooden, MD, FACS; Susan Yendro, RN, BSN.

***NQF Staff*:** Lisa Hines, BSN, MS (Senior Program Director); Melissa Marinelarena, RN, BSN (Program Director); Helen Burstin, MD, MPH (Senior Vice President of Performance Measures)

WELCOME, INTRODUCTIONS, DISCLOSURES OF INTEREST

Ms. Marinelarena began the meeting by welcoming the committee and asking that each committee member introduce themselves. Ms. Hines provided an overview of the project to date, the timeline, and the NQF consensus process. Dr. Burstin summarized several NQF strategic issues for the Committee to take into consideration including the purpose of building a framework for the prevention and management of pressure ulcers to facilitate future performance measurement development in these areas.

Following the welcome, the Steering Committee (SC) members introduced themselves and made disclosures. The following SC members disclosed various work related to pressure ulcers. Debra Saliba disclosed she just completed work on MDS 3.0 for nursing homes which does include a section on pressure ulcers. Ben Peirce disclosed he is the Treasurer for the Wound Ostomy Continence Nurses Society. Caroline Fife disclosed she owns and operates an electronic medical record company that collects and analyzes data pertaining to wound care. Sandra Berquist-Beringer disclosed she is the Pressure Ulcer Consultant to the National Database of Nursing Quality Indicators (NDNQI). There were no other conflicts of interest to disclose.

Following the disclosures of conflict of interest Deb Saliba and Ben Peirce reviewed the Steering Committee charge and project scope.

WORK GROUP DISCUSSIONS

The Steering Committee was divided into three work groups the first day of the meeting to identify issues pertinent to the framework domains. On the second day of the meeting the work groups were reconvened for the remainder of the meeting to work together to draft the framework. In their discussions the Committee was asked to consider all age groups and care settings in the discussion.

The first work group included: Courtney Lyder, Caroline Fife, Katherine Chick, Jeanine Maguire, Jean DeLeon and Susan Yendro. The group was tasked to discuss measuring and staging of pressure ulcers. Some of the discussion points the group was asked to consider included but not limited to:

- List appropriate measure and staging including appropriate tools/scales. Include:
    - temporarily "unstageable"
    - scoring systems
    - multiple lesions and deep tissue injury in evolution
- Provide any definitions for terms
- Provide any guidance for performing these activities
- Provide clarification for any misconceptions or known errors in performance

The second work group included: Mary Hagle, David Smith, Catherine Ratliff, Deb Saliba, Theresa Edelstein, Dan Berlowitz, and Sandra Berquist-Beringer. The group was tasked to discuss analytics. Some of the discussion points the group was asked to consider included but not limited to:

- Measuring the incidence and prevalence of pressure ulcers and the pros and cons of both
- Performing analysis at multiple levels, including providers, systems, communities, and geographical areas
- Determining accountability as the patient moves across settings of care, i.e., present on admission, etc.
- Identifying any potential pit falls
- Draft standard specification with numerator and denominator including exclusion for various pressure ulcer measures (process, outcome, populations)

The third work group included: Lynn Carpenter Moore, William Wooden, Donald Thomas, Nancy Tomaselli, George Taler, Ben Peirce, and Margaret Birdsong. The group was tasked to discuss prevention and healing of pressure ulcers. Some of the discussion points the group was asked to consider included but not limited to:

- List proper prevention techniques and equipment for specific population or clinical situations
- List proper healing strategies for various populations or clinical situations
- Identify any outdated prevention or healing strategies that should not be used (e.g., wet to dry dressings)

- Provide any definitions for terms

WORK GROUP DISCUSSIONS AND DELIBERATONS SUMMARY TABLE

MEASURING AND STAGING PRESSURE ULCERS

List appropriate measure and staging including appropriate tools/scales. Include: • *temporarily "unstageable"* • *scoring systems;* • *multiple lesions and deep tissue injury in evolution;*	**Staging Discussion**: Current system issues: 1. Not linked to treatment or outcome 2. Unstagable category is problematic and hasn't been accepted in Acute Care 3. 'Staging' implies progression of which lacks pathophysiologic evidence 4. Other 'Staging' systems in medicine often imply severity and anticipate decline- as in Metatastatic Cancer, i.e. stage of cancer, determines treatment, which in turn determines outcome 5. Additionally, the label of stage I 'Ulcer' referring to closed skin is very misleading. Assessment requires explanation and palpation- not just a picture 6. Stage I ulcers are often missed with darker skin. Is it difficulty in assessing or is it differences in vascularity? 7. Pressure ulcers can occur both ways, from the inside out or the outside in. There are no studies on the natural evolution. Studies done with US support. The answer may lay in technology- 8. If the observation is mushy/boggy- the opportunity to prevent is lost. 9. Stage IVs with bone exposure are different for healing 10. Blisters are evidence of superficial tissue injury 11. 'Grading System' would be more appropriate; currently used in Europe Further discussion regarding recommended changes → staging to grading: 1. Should all wounds be included? 2. Should shearing and skin tears be included in partial thickness injury category? **Concern**: skin tears require different treatment 3. **Proposition:** Acquired Wound System vs. Surgical Wound System**.** Combine diabetic foots ulcers, venous statis ulcers, etc. and include categorize as "acquired" 4. There is concern that 'acquired' assumes the ulcer was acquired in-house vs. acquired in the community 5. **Clarification:** surgical vs. nonsurgical instead of acquired vs. surgical 6. Acute and chronic could also be included but this would make the proposed grading system more complex

	Summary: • There are limitations in the current 'measuring' system to accurately measure quality • The CARE Tool is leading toward getting away from the term 'staging' • Grouping pressure ulcers and venous ulcers may not provide a true indicator of quality; grouping various types of ulcers/wounds requires further research • Pressure ulcers should be 'graded'separately from all other wounds/ulcers; • Deep structure involvement such as bone involved should be a sub-category. • There is a difference between bone exposure and bone involvement; bone involvement refers to complications such as osteomyelitis whereas bone exposure refers to exposed bone or structures **Research Recommendations**: • Utilize technology available for staging • Is there literature available that looks at some characteristics that can be used to measure severity and can be used as quality indicators? • Look at research to predict healing: percent of closure at 1 week and at 4 weeks (10-15% at week 1…) (If you don't achieve a 50% area reduction within 12 weeks you can highly predict it will not close) **Wound Measurement Discussion:** • What is needed to define improvement? What will the public understand? • What is the goal for collecting information on multiple lesions? Quality reporting, payment, pay for performance, public reporting, etc. • GOAL: to obtain standardization across settings • If the recommendation is to now only 'measure' full thickness ulcer- should the PUSH score be considered? • Measuring partial thickness raises questions regarding defining wound edge • Need to define pressure ulcer edges→pink areas→how far out does one measure? • The PUSH tool challenges include larger wounds and absence of measurement of depth • A tool that combines these ideal elements would be useful: 1. LxW 2. Depth 3. Tissue type % (i.e. necrotic, eschar, etc.) 4. Undermining/tunneling • Exposed structures may be a picture of 'severity' rather than a reporting element for outcomes. Should this be included in a 'risk adjustment' rather than serial reporting?

	• Technology is available such as tracing systems • An industry 'minimal' standard is needed but facilities who have established advanced measuring technology should continue to use it • Certain interventions, like wound debridement, may increase size pressure ulcer but does not imply poor care; size is an inadequate determination of quality in such cases • Time intervals must be taken into account; may be different in acute care vs. long-term care • Healing most likely does not occur in acute care; instead there may be an increase in the size of the pressure ulcer due to debridement • Three methods discussed: 1. 12:00-6:00 2. Longest Length 3. 'boxed-in' – boxing method sufficient more advanced methods are readily available Access Dr. Taler's power point presentation here. • Longest length makes more sense when no anatomical structures are available for head to toe measurement • Accuracy is not as important as simplicity and consistency • Clinicians will continue to 'dipstick' to measure depth • Concern: positioning of patient (i.e. knee bent, head elevated 45 degrees, etc) may alter pressure ulcer measurement → requires pressure ulcer standardized practices to address Further Research needed: • A study that looks at healing rates by wound location (including heels, sacrums, Ischial tuberocity) o Delineating locations is difficult due to the current coding system that does not separate ischial tub from sacrum. o Co-morbid diseases that may change the wound 'diagnosis', such as Diabetes and Arterial- need to find and review this: • Jean Donnally- heel pressure ulcers, Tissue Viability Nursing **Multiple Lesion/Public Reporting Discussion:** • If reporting, report only the worst pressure ulcer • Worse pressure ulcer considered to be the largest full thickness pressure ulcer in one area • Scales are currently available to demonstrate improvement of pressure ulcers although currently available scales are not validated as outcomes • No current scale the Steering Committee supports but Steering Committee is willing to support parameters

	• For public reporting into a database**:** 1. number of pressure ulcers – partial thickness and full thickness 2. largest full thickness pressure ulcer on different areas (i.e. sacrum, spinal, elbows, heels, etc.) • Currently no evidence based literature available to demonstrate that pressure ulcer characteristics such as drainage is a sign of improvement • Do we want to report additional characteristics on 'worst' pressure ulcer? • Pressure ulcer framework can distinguish between quality improvement and public reporting
Provide any definitions for terms	**Definitions Discussion:** • Consider the NPUAP wording, like 'no slough' into definitions • Can this be used for all wounds? Non-surgical wounds only • Can the definitions include more about the etiology (debrided, known pressure ulcer, unknown, shear, vascular component, mixed etiology…) • If deep structure involvement was noted, there should be a sub-category under 'Full Thickness'. Either proven by visible exam or through technology to verify. • There are other staging/grading systems available. University of Texas has a system. The Wagner's scale is another. We made need research in this area. **Steering Committee Recommendations**: **Steering Committee recommended changes to current staging system:** • Stage I and II: Partial thickness injury • Stage III and IV: Full thickness injury The following is the basic information required to track outcome and severity. A full assessment is still required to determine treatments/interventions. 1. Factors that could track severity and outcome: a. Size (LxWxD), b. necrosis c. undermining/tunneling/ sinus tracks/ exposed structures 2. Documentation of Multiple Pressure Ulcers : • #of partial and

	• # of Full 3. Tracking ulcers: • Partial: closed vs. open • Dimensions (L,W,D) of the largest full thickness **Steering Committee Measurement Descriptions**: • Length: Longest length encompassing the wound, head-to-toe for orientation • Width: perpendicular to length • Depth: Deepest vertical depth, according to the intact wound edge • There are tools/scales available, but they have not been demonstrated to link to outcomes • Tools currently used to describe healing: PUSH, Bates Jenson tool, Sonata **Steering Committee Recommendation Pressure Ulcers to be Publicly Reported:** 1. Number of partial thickness and full thickness pressure ulcers 2. The worst pressure ulcer such as the largest full thickness pressure ulcer; if patient does not have any full thickness pressure ulcers then the largest partial thickness pressure ulcer should be reported **Steering Committee Recommended Definitions:** • Partial thickness injury: includes intact skin with color change and superficial open areas and clear fluid filled blisters. Describe whether area is open or closed (Stage I, II). o Healed once reepithelialized or color change has resolved. • Full thickness injury/ulcer: Full thickness with involvement of underlying structures. This would include deep tissue injury (DTI) ,purple pressure ulcers and blood filled blister and unstagable (Stage III, IV, UN, DTI). Describe whether it is open or closed. DTI: Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure ulcer and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. • Once a full-thickness ulcer has re-epithelialized,' it should be considered 'closed' rather than 'healed'. There is a paucity of research that suggests that remodeling occurs over a two year time period. o Potential research- find: Vicent Falanga and Morris Kirstein MD, and Laura Edelstein o Need more research in this area to determine a time-frame o Once a pressure ulcer is determined to be a full thickness injury it will always be a full thickness injury (language from NPUAP such as slough may be helpful for clinicians)

Provide any guidance for measuring a pressure ulcer	**Steering Committee Recommended Measuring Guidance** To measure a pressure ulcer use: 1. Length: Longest length, head to toe 2. Width: perpendicular to length 3. Depth: Deepest vertical depth 4. Area: encompassing the pressure ulcer Vote: Yes: 19, No 1 • Steering Committee recommends to 'dipstick' in multiple areas to obtain deepest depth

ANALYTICS

Measuring the incidence and prevalence of pressure ulcers and the pros and cons of both	**Incidence and Prevalence Discussion:** Established definitions of incidence and prevalence: Incidence: numerator: # of people who acquire the event in question denominator: # of people within the population under question Prevalence: numerator: # of people who have the event under question denominator: population under question INCIDENCE PRO: • incidence most accurate using database • Prevalence without POA INCIDENCE CON: • problems in defining POA (present on admission) for incidence

	• Done differently in different settings
	• Only LIP documentation
	• Time intensive; requires extensive resources
	• Difficult to do
	
	  • Incidence proxy measure used in long term care or acute care due to the difficulty in measuring is measuring incidence in these facilities.
	  • Facility acquired or hospital acquired measures refers to pressure ulcer that was not present at time of admission to facility – acknowledge it is not a true measure of incidence but a proxy.
	  • 2 point prevalence difference; those who did not have a pressure ulcer on admission and those who have a pressure ulcer after admission.
	
	What do you measure at start of care?
	• LTC: staff screen patient closely to determine if pressure ulcer was present due to LTC being penalized; home care screen patient closely to determine if pressure ulcer was present due to reimbursement impact
	• hospital setting should be the same – admission assessment to determine present on admission
	• admission assessment including skin assessment be the standard for present on admission; need to closely assess skin for presence or absence of pressure ulcer
	• look at two points: start of care and end point during episode or discharge
	
	Concerns/discussion:
	• additional incentives in home care to document pressure ulcers at start of care due to potential increase in revenue – compensation in supplies for dressings, etc.
	• concern of potential for gaming with OASIS and MDS in home care and LTC
	• hospital setting: POA data now available – unaware of implications of reliability and validity of pressure ulcer reporting in hospital discharge databases (ICD-9 codes): prior to POA pressure ulcer requirement, pressure ulcers not reported in databases
	• need to clarify intent of measures to be used for internal QI or public reporting – measures may differ depending on the setting
	
	What stages should be included in the measures?
	• Stage III and Stage IV – publicly reported and should be considered sentinel events or never events
	• "unstageable" – to be included with Stage III and Stage IV for measuring and public reporting because experts

	agree a pressure ulcer cannot be unstageable due to the presence of necrotic tissue without being a Stage III or IV in etiology • Should public reporting include Stage I PU? – frequent reporting of Stage I may indicate high quality if interventions are put into place and further pressure ulcers are avoided; however a Stage I does indicate pressure – consensus not reached if Stage I should be reported at this point in the discussion • Stage II should be reported for internal QI and public reporting; concern of small numbers if Stage II reported separately which could cause unstable numbers – include Stage II with Stage III and Stage IV for public reporting • Reminder: measurement and staging group recommended to combine Stage I and Stage II pressure ulcers into partial-thickness injury. Stage II and Stage IV, unstageable and DTI will be classified as full-thickness injury • Both partial and full-thickness injuries will be reported • According to analysis from NDNQI – only reporting Stage III/IV pressure ulcers leads to 82-86% of pressure ulcers unreported • Deep Tissue Injury(DTI): insufficient evidence to group with III/IV – evidence inconclusive at this time – but experts agree pressure ulcers begin in soft tissue; SC recommends re-evaluating DTI as evidence immerges • Wounds/ulcers will only refer to pressure as primary ideology of the wound **not** venous, diabetic, etc. **Discussion Summary:** 1. setting acquired ulcers acceptable way of measuring incidence 2. setting acquired definition- • present on admission (POA) parameter needs to be established • start: assessment on admission • possible endpoints: discharge assessment (CARE Tool does this), quarterly assessment, or other assessment conducted after admission to capture setting acquired pressure ulcers 3. start and endpoint assessment- Endpoint should capture pressure ulcers acquired since start of care and would determine if pressure ulcer is hospital/facility acquired 4. move toward real-time reporting vs. retrospective reporting **WHAT PRESSUR ULCER TO MEASURE SUMMARY:** • Stage 1: important for internal QI work and should be collected internally; still part of national databases • Stage 2: internal QI work

	• Stage 3 and 4 – never events; measured; real time, publicly reported • Public reporting concerns: errors in defining stage 1 and detection bias; rate of healing is greatly different from Stage 3 and 4. If to keep separate, need to balance data stability of small frequency of Stage 3 and 4 before publicly reported. (possible, only larger facilities; longer time frames; report processes). Unstageable: • QI measure and combine with Stage 3 and 4. • Publicly report (issues: dry heel eschar vs. Stage 4 and resources used and how viewed). DTI: • Important to track data, keep separate from other types of PU. **Steering Committee Recommendations:** **For public reporting:** 1. real time reporting, 2. PU that occurred between start and endpoint assessment will be counted (reported). Endpoint should capture pressure ulcers acquired since start of care and would determine if the pressure ulcer is hospital/facility acquired. **POST MEASURE/STAGING DISCUSSION:** **QI measure and public reporting for Partial and Full-thickness pressure ulcer wounds** RESEARCH RECOMMENDATIONS: • risk factors for stage 1 only vs. risk factors for stage 2 or higher • Relationship between stage 1 and other issues such as quality of care, internal QI, • What is sample size to have stability for Stage 3 and 4 data? • Methods to handle small PU occurrences, i.e., Stage 3 and 4; 2? • Ability to measure time to occurrence.
Performing analysis at multiple levels, including providers, systems,	**Steering Committee Recommendations:** • Setting-acquired ulcer = incidence • Risk adjustment: should be part of public reporting but must first determine if the development of a pressure ulcer

communities, and geographical areas	should never happen and be considered a sentinel event, then no risk adjustment is needed. However, if it is determined the development of a pressure ulcer is not completely preventable, then risk adjustment is necessary. • Recommendation: include robust, clinically and statistically credible, risk adjustment models for public reporting for hospitals • In absence of this, use risk stratification based on hospital size and unit type endorsed by NQF • At this point of time, panel unable to identify current evidence based model, thus need to develop effective tool for risk stratification for public reporting • Minimally include functional status, and basic level of mobility to be included. • Achieve consistent end points for measurement • Real time reporting Discussion on methods and issues around risk adjusting, e.g., unit type may be proxy for risk. Considerations also include functional status, current severity index used by hospitals. **POA is based on a window of time needs to be decided. To be done by measures team – federal law currently defines POA – only in acute care settings – in physician documentation that wound was in fact present at time of admission to facility; if discourse between physicians and nurses' notes, physician indicated by medical records to clarify discrepancy* **Important to operationalize this construct. Minimize error. Consider readmissions and how varies across settings.* • Lack of data to operationalize present on admission
Draft standard specification with numerator and denominator including exclusion for various pressure ulcer measures (process, outcome, population)	**Steering Committee Recommendations:** **INCLUSION AND EXCLUSION PRINCIPLES:** • Be as inclusive as possible; but where preventive measures are contraindicated for specific individuals, may be excluded. Examples include: an immobile patient who declines replacing the bed with a pressure redistribution support surface, or a malnourished patient who eats little, despite maximal provider support for that setting, and declines a feeding tube. • Exceptionally low risk populations may be excluded (normal obstetrics). • Keep track of patients who are not included due to refusals, off unit, unstable, etc. • Exclusion criteria should be ID first. • For public reporting, criteria need to be clear and monitored. • Hospitalization duration: short stay pts may be excluded, i.e. 48 hour cardiovascular hospital – risk adjust to avoid skewing data - *Have to define short stay, such as 'observation' patients, well ambulatory patients*

	Risk-adjustment: • Development of risk adjustment models for hospitals; consider the structural/quality/outcome link for any risk adjustment, including why a variable (e.g. hospital size, unit type) might influence outcomes when constructing risk adjustment.
Additional Note:	Via email: discuss deep structure involvement *no evidence full thickness begin in soft tissue and may not emerge in time, sometimes longer than two days-no evidence but widely accepted – as evidence is identified need to relook at this issue

PREVENTION AND HEALING

List proper prevention techniques and equipment for specific populations or clinical situations	**Steering Committee Discussion:** • Plan of care is tied to the implementation -Was there a plan of care and was it implemented is needed for quality measures • Both skin assessment and pressure ulcer risk screening are components of the comprehensive assessment needed to manage and prevent pressure ulcers • Critical to identify risk assessment initially, but may not need to be done after that especially at high risk. • All studies for acute care identified at risk or not at risk. Once at risk, do not do any more risk assessments. • Significance of subscales-not tied to guiding care. • Action based on assessment • Reassessment in acute care-pt condition can change rapidly • Who is at risk and type of intervention-for anyone at risk **Steering Committee Recommendation::** Screen all patients with a head-to-toe skin assessment and formal risk assessment during all comprehensive (repetitive and sequential) assessments and integrate the assessments into an interdisciplinary plan of care and to the care provided to the patient and communicate across care settings. • Add head to toe skin assessment in first paragraph within 8 or 24 hours of admission

	Integrate monitoring this at the PI level (assessment links to implementation). Training and Education: 1. Educate students in core curriculums in primary professional training 2. Educate staff by professional training and ongoing competency at all levels 3. Educate patients and caregivers in prevention and treatment strategies Prevention Strategies: 1. Consider prognosis and goals of care 2. Pressure redistribution (bed and chair) 3. Nutrition & hydration (weight status and other parameters) 4. Turning for bed and chair - not a specific timeframe (DeLatt) will leave to each facility or available guidelines 5. Management of incontinence 6. Maintain good hygiene 7. Daily or repetitive skin inspection for at risk patients Supporting Effective Care Transition 1. Transfer of care plan to follow the patient to all care settings
List proper healing strategies for various populations or clinical situations	**Steering Committee Discussion:** • Palliative care needs to be clearly and explicitly further defined if is referenced in a measure. PU prevention and treatment may still be a goal of care depending on the individual patient • Timeframe for reconsults? Federal Tag 314 says 2-4 weeks. 4 weeks in an acute setting is too long-2 weeks was proposed and needs further deliberation. • Evaluate progress weekly • Add patient adherence to POC **Steering Committee Recommendations:** Wound care strategies should be aligned with the patient's overall condition, prognosis and goals: 1. Tailor plan of care to wound healing v. palliation. 2. Develop a realistic care plan in collaboration with the patient and caregivers.

	Wound management should be guided by regular, comprehensive patient assessment (deficits in perfusion, oxygenation, metabolism, weight status) and wound assessments (including size, wound bed appearance, quality and quantity of exudate, periwound skin): 1. Identify and manage infection. 2. Debride devitalized tissue as appropriate. 3. Maintain moist wound bed and manage wound exudate. 4. Maintain effective pressure redistribution (positioning in bed and chair and transferring techniques). 5. Manage incontinence. 6. Provide nutrition and hydration support. 7. Maintain overall management of co-morbidities including psychiatric conditions 8. Protect periwound skin and monitoring for secondary iatrogenic trauma (eg. skin tear) 9. Manage pain (local and systemic) 10. Perform regularly scheduled wound evaluation to determine wound progress or deterioration. 11. Careful consideration of medications or therapies that may inhibit wound healing (eg. antineoplastics, anti-inflammatories) 12. Incorporate interdisciplinary approach and resources through inter-professional communication. 11. Increase strength, endurance and mobility. In wounds failing to show effective progress in an evidence-based timeframe, reassess the patient's wound status, the patient's overall medical status and prognosis to guide interventions. 1. Reconsider acute and chronic disease states, iatrogenic states and medications. 2. Reassess or confirm causation of injury and impediments to wound healing. 3. Revaluate for previously unidentified underlying pathological conditions. 4. Seek additional consultation as appropriate.
Identify any out dated prevention or healing strategies that should not be used (e.g., wet to dry dressings)	**Steering Committee Discussion:** • Wet to moist can be used after acute debridement or when trying to frequently assess a wound and is appropriate when transitioning from 1 therapy to another for a short term use. • There was concern it would be used on a long term basis so there is not a resurgence of wet to dry dressings for chronic wounds.

	Steering Committee Recommendation: Avoid donuts seat cushions for pressure redistribution Avoid sheepskin for pressure redistribution (there may be some new literature on friction and shear) Hydrotherapy in clean wounds; is a concern from an ID standpoint Avoid cytotoxic solutions in clean wounds cleansing Avoid heat lamps Avoid hair dryers Avoid wet to moist dressings as a long term treatment (may be appropriate as a short term option (eg. perioperative management of wounds.) (pain, frequency of dressing changes, spread of infection) Avoid packing materials that tend to matt or are non-resilient*
Provide any definitions for terms	Pressure redistribution Devices for pressure redistribution Non-resilient Cytotoxic solutions **Palliative care** is any form of medical care or treatment that concentrates on reducing the severity of disease symptoms, rather than striving to halt, delay, or reverse progression of the disease itself or provide a cure. The goal is to prevent and relieve suffering and to improve quality of life for people facing serious, complex illness. (source: wikipedia.org, accessed 3/4/09) Goals of palliative wound care may include: preventing infection, pain management, and exudate management and odor control for psychosocial support. Patients: applies to all care settings The formal comprehensive assessment process includes comprehensive assessment by each

	discipline and then integration into a medical care plan. Care Transition Devitalized tissue Negative pressure wound therapy Evidence based timeframe
Additional Notes: **Can cite references by number**	*Avoid using patient care and/or wound care products in a way that result in a matted or non-resilient mass that could produce a point of pressure in the wound (eg. dense gauze, negative pressure wound therapy) in weight bearing areas (expert opinion). Avoid use of wound care products as a preventive measure over bony prominences that inhibit skin reassessment (expert opinion). Strict attention to pressure relief and failure to promote wound collapse needs to be monitored Balance patient functional independence with the wound management strategy.

NEXT STEPS

Upon drafting the framework the Steering Committee will apply the framework criteria to currently NQF-endorsed pressure ulcer measures and pressure ulcer measures currently under review in the Consensus Development Process (CDP) in order to identify revisions that will need to be requested of the measure owners.

The discussion points and final recommendations will be included in a draft report disseminated for member and public comment mid-March.