NHS Improvement

Pressure ulcers: revised definition and measurement

Summary and recommendations

June 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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Foreword

Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. In the NHS in England, 24,674 patients[1] were reported to have developed a new pressure ulcer between April 2015 and March 2016, and treating pressure damage costs the NHS more than £3.8 million every day. Finding ways to improve the prevention of pressure damage is therefore a priority for policy-makers, managers and practitioners alike.

Studies examining pressure ulcer occurrence indicate that quantifying pressure ulcers is complex: the type of data collected and methods used during collection vary, which makes valid data comparisons difficult.

It is recognised that collecting and understating data on the causes of harm is a key tenet of quality improvement approaches in healthcare. Accurate measurement must accompany a quality improvement method to make changes and improve outcomes for service users and patients.

The recommendations in this document are designed to support a more consistent approach to the definition and measurement of pressure ulcers at both local and national levels across all trusts.

We anticipate that full implementation of the recommendations from April 2019 will improve understanding of the level of pressure damage harm in England. This will in turn support an organisation's ability to learn from reported incidents and inform the quality improvement programmes that are required to help reduce reported

[1] Data from the NHS Safety Thermometer.

pressure damage and improve the quality of care. Work to support the implementation will continue until March 2019.

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Summary

Pressure ulcers remain a challenge for the patients who develop them and the healthcare professionals involved in their prevention and management. Despite extensive prevention programmes, evidence suggests about 1,700 to 2,000 patients a month develop pressure ulcers.[1]

As part of a national patient safety agenda, NHS England has introduced several initiatives in recent years to reduce avoidable pressure ulcer (PU) harm. These include reporting prevalence through the NHS Safety Thermometer,[2] incident reporting systems and the Strategic Executive Information System (StEIS)[3] for reporting Serious Incidents. Despite the limitations of the Safety Thermometer's database (a monthly point prevalence tool), no other national system yet exists for reporting pressure ulcer incidence. Although these initiatives were implemented across the NHS, lack of comprehensive guidance has led to concerns about variation in local implementation (eg type of ulcer to be reported, classification system to be used) and subsequent inconsistency in reporting pressure ulcers. Literature reviews have also identified difficulties in interpreting adverse event data.

Data from an audit and survey in 2016[4] indicated that current systems used locally, regionally and nationally to monitor PU patient harm lack standardisation. They are also characterised by high levels of under-reporting. Yet despite their limitations, they have been used to compare trusts, and in some cases lead to financial penalties. This work led to key recommendations to improve future PU monitoring.[5]

The national Stop the Pressure programme led by NHS Improvement has developed recommendations for trusts in England. These support a consistent approach to defining, measuring and reporting pressure ulcers. Our intention is to

[2] https://www.safetythermometer.nhs.uk/
[3] https://improvement.nhs.uk/resources/steis/
[4] Smith IL, Nixon J, Brown S, Wilson L, S Coleman (2016) Pressure ulcer and wounds reporting in NHS hospitals in England: Part 1 – audit of monitoring systems: *Journal of Tissue Viability* (2016/2/1).
[5] Coleman S, Smith IL, Nixon J, Brown S, Wilson L (2016) Pressure ulcer and wounds reporting in NHS hospitals in England: Part 2 – survey of monitoring systems. *Journal of Tissue Viability* 25 (2016/2/1).

provide for each trust an accurate profile of pressure damage so it can improve quality by reducing the harm that patients experience.

Our recommendations were developed by task-and-finish groups with a broad range of clinical and academic experience. One group looked at recommendations for definition and one at local and national measurement.

We used a consensus approach to maximise engagement, sharing information across the task-and-finish groups and with the national programme steering group. The national Stop the Pressure programme has also designed a pressure ulcer audit tool to give trusts greater insight into their pressure ulcer practice for use alongside the revised definition and measurement framework. We plan to make this available in autumn 2018.

Recommendations

It is important that the reported profile locally and nationally accurately reflects the type of pressure ulcers/damage. Our recommendations below, for the NHS in England, are designed to be consistent with some of the existing approach to definitions, but also to raise the profile of ‘hidden’ categories of pressure damage, such as deep tissue injury and medical devices pressure damage. Better understanding of pressure damage will enable trusts to learn from incidents and design appropriate improvement work in response to their profile.

For each recommendation we provide a rationale and an impact assessment for reporting and clinical practice. We identify actions leads and suggest an indicative timeframe for completing the action.

Table 1: Recommendations on the definition of pressure ulcers

Recommendation	Rationale / likely impact / action lead
1. We should use the term 'pressure ulcer'.	***Rationale*:** This position will be different from some other countries, but it is a term widely used already in the UK and is consistent with the European Pressure Ulcer Advisory Panel's definitions. ***Impact:*** We do not anticipate it will affect reported numbers.
	Action leads by December 2018*:** **NHS Improvement** to amend relevant national documents with NHS England colleagues. ***Trust boards: To amend relevant policy documents.
2. A pressure ulcer should be defined as: "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open ulcer and may be painful".	***Rationale:*** There has been no agreed definition previously. This is a new definition in practice, which will be used in educating staff. ***Impact*:** No impact on reported numbers.
	***Action lead*: NHS Improvement** has incorporated this definition in the new pressure ulcer education curriculum. This will be rolled out during 2018/19 in all providers and – we anticipate – relevant academic institutions, to support a consistent approach in education.
3. A pressure ulcer that has developed due to the presence of a medical device **should** be referred to as a 'medical device related pressure ulcer'.	***Rationale*:** New definition to be used in practice, which will reflect the level of pressure ulcers caused by medical devices as these are currently under-reported. ***Impact*:** This new definition will need to be incorporated into national and local incident reporting systems.

Recommendation	Rationale / likely impact / action lead
	Action leads by December 2018*: NHS Improvement** working with NHS England colleagues to amend relevant national documents, and work with NHS Digital to incorporate this category in national reporting systems, eg National Reporting and Learning System. ***Trust boards: To review their local policies and reporting approaches and implement the new definition in practice.
4. The National Pressure Ulcer Advisory Panel's (NPUAP) 2015 definition of device-related pressure ulcers **should** be used: "Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes".	***Rationale:*** No change to current practice; the NPUAP definition is widely used in clinical practice. ***Impact*:** As Recommendation 3.
	Action leads: As Recommendation 3.
5. A pressure ulcer that has developed at end of life due to 'skin failure' should **not** be referred to as a 'Kennedy ulcer'.	***Rationale:*** Pressure ulcers at end of life should be classified in the same way as all pressure ulcers, and not be given a separate category. ***Impact*:** This term will cease to be used in reporting and clinical practice across all trusts.
	Action leads by December 2018*: NHS Improvement** working with NHS England colleagues to amend relevant national documents. ***Trust boards: To review their local policies and reporting approaches and implement the new approach in practice.
6. Organisations should follow the current system recommended in the "international guidelines, NNPUAP/EPUAP/PPPIA (2014)" incorporating categories 1,2,3,4.	***Rationale:*** Minimal change to current practice; current system is well understood in clinical practice. Aim to standardise across all trusts. ***Impact:*** No anticipated impact.
	***Action lead by December 2018 – trust boards*:** Where relevant, trusts boards to amend their local policies.

Recommendation	Rationale / likely impact / action lead
7. Organisations **should** follow the current system recommended in the international guidelines, NPUAP/EPUAP/PPPIA (2014) incorporating deep tissue injury (DTI).	***Rationale*: This will lead to the recording of DTI, which is currently not recorded in some trusts, and support early clinical intervention where required. ***Impact:*** This will lead to a different reporting profile in local and national measurement systems.
	Action leads by December 2018*: NHS Improvement** working with NHS England colleagues to amend relevant national documents. ***Trust boards: To review their local policies and reporting approaches and implement the new definition in practice.
8. Organisations **should** follow the current system recommended in the international guidelines, NPUAP/EPUAP/PPPIA (2014) incorporating unstageable ulcers.	***Rationale:*** This will lead to the recording of unstageable ulcers. ***Impact:*** This will lead to a different reporting profile in local and national measurement systems for most trusts. No impact on clinical practice.
	Action leads by December 2018*: NHS Improvement** working with NHS England colleagues to amend relevant national documents. ***Trust boards: To review their local policies and reporting approaches and implement the new definition in practice.
9. The definition of a pressure ulcer on admission (POA) **should** be that it is observed during the skin assessment undertaken on admission to that service.	***Rationale:*** A new definition in practice to provide a consistent approach to attributing ulcers, and to support quality improvement activity in appropriate clinical areas. ***Impact:*** Impact on reporting practice in terms of attribution will focus organisations on identifying damage early.
	Action leads by December 2018:* NHS Improvement/NHS England** to amend relevant national documents. **NHS Digital** to consider inclusion in Hospital Episode Statistics. ***Trust boards: To amend local policies and implement the revised approach.

Recommendation	Rationale / likely impact / action lead
10. The Department of Health and Social Care's definition of avoidable/ unavoidable **should not** be used.	***Rationale:*** Ceasing use of these terms will lead to **all** incidents being investigated to support organisational/system learning and appropriate actions; to move from focusing on 'proving' if an incident was unavoidable to using a range of definitions in practice. This is consistent with other categories of patient safety incidents. ***Impact:*** All incidents will need to be investigated, resulting in more pressure ulcers being recorded/reported by individual providers. There is likely to be an impact on local NHS contracts, as the existing approach is embedded in them.
	Action lead by December 2018: **NHS Improvement/NHS England** to review all relevant documents, including commissioning approaches, to help implement this recommendation. ***Trust boards:*** To review local documentation and implement the change in practice, to educate all staff about the changes in practice. ***Commissioners:*** To support implementation of this recommendation, including in their oversight of investigation.
11. The definition of a new pressure ulcer within a setting is that it is first observed within the current episode of care.	***Rationale/impact*****:** New definition for use in practice. Rationale and impact as Recommendation 9.
	Action leads by December 2018: **NHS Improvement/NHS England** to amend relevant national documents. ***Trust boards:*** To amend local policies and implement the revised approach.
12. The term 'category' should be used from October 2018 at a national level (in national reporting/policy documents).	***Rationale:*** To consistently apply terminology in national reporting. ***Impact*****:** No reporting of clinical practice impact; impact on policy documents.
	Action lead by October 2018: **NHS Improvement** to amend relevant national documents.

Recommendation	Rationale / likely impact / action lead
13. Local organisations from October 2018 **should** work towards using the term 'category' in clinical practice and local reporting/policy documents, with full implementation by end October 2018.	***Rationale:*** To support the consistent use of terminology within policy documents. ***Impact*:** Updating where relevant local policy documents.
	Action leads by October 2018 – trust boards: To review their local policy documents.

Table 2: Recommendations on the local and national measurement of pressure ulcers

Recommendation	Rationale / likely impact
14. The '72-hour rule' **should** be abandoned.	***Rationale:*** This is an artificial split irrelevant in clinical practice due to the complexity of patient pathways. This will be consistent with the definition of a pressure ulcer on admission. Recording all pressure damage will ensure a review of incidents and support organisational learning and taking appropriate action for all incidents. ***Impact*:** Moderate impact on the NHS Safety Thermometer model; the rule would need to be changed to include all pressure ulcers, and so affect the NHS Safety Thermometer data.
	Action lead by December 2018: **NHS Improvement** to work with the National Patient Safety Team to amend the NHS Safety Thermometer's reporting approach for pressure ulcers and other harms. ***Trusts boards:*** To review their local reporting policies and implement the revised approach.
15. Reporting of **all** pressure ulcers **grade 2 and above** on admission (POA) pressure ulcers (which is observed in the skin assessment on admission to that service) **should** be incorporated into local monitoring systems.	***Rationale:*** To ensure that all pressure damage regardless of attribution will be captured in local monitoring systems, supporting a more accurate profile and appropriate actions. ***Impact:*** Likely impact of higher reported numbers and changing profile across individual providers.

Recommendation	Rationale / likely impact
	Action lead by December 2018 – trust boards: To review local practice to ensure this is implemented consistently, to prevent double-counting or false reassurance when 'POA' to a unit, ward or team does not mean POA to the trust as a whole.
16. Device-related pressure ulcers **should** be reported and identified by the notation of (d) after the report – eg Category 2 PU (d) – to allow their accurate measurement.	***Rationale/impact*:** The rationale/impact for the reporting of medical device pressure ulcers outlined in Recommendation 3.
	***Action leads by December 2018*:** As Recommendation 3.
17. Kennedy ulcers should **not** be measured separately.	***Rationale*:** As Recommendation 5, that Kennedy ulcers will no longer be measured as a distinct category. Pressure damage at end of life will be recorded as pressure ulcers. ***Impact*:** This category will cease to be reported nationally. There may be a small increase in PU numbers as traditionally Kennedy ulcers were not reported in PU datasets.
	Action leads by December 2018 – trust boards: To review their local policies and reporting approaches and implement the new approach in practice.
18. All reports should identify the patient using the NHS number, not the hospital number, to help reduce duplication of reporting.	***Rationale*:** New approach to reduce double-reporting of pressure ulcers due to the inconsistent use of patient identification numbers. ***Impact:*** Unknown, but the use of a single patient identification number has been mandatory since the Health and Social Care (Safety and Quality) Act 2015, while use of the NHS number has been recommended since 2016, and many organisations have begun work on this.
	***Action lead by December 2018:* NHS Improvement** to assess the likely benefits of this approach in practice, in terms of reducing double-reporting.

Recommendation	Rationale / likely impact
19. Reporting Category 2 and above pressure ulcers **should** be incorporated in local monitoring systems.	***Rationale*:** No change to current practice recommendations but to ensure all trusts are consistently following this reporting approach. To identify/report pressure damage at an earlier stage, to support earlier clinical intervention and prevent deterioration. ***Impact*:** Focus on consistent implementation may affect overall reported numbers.
	Action lead by December 2018: Trust boards to review their current practice and implement changes as required to local reporting.
20. Reporting unstageable pressure ulcers **should** be incorporated into local monitoring systems.	***Rationale*:** To reduce variation in reporting across trusts. To support timely identification of pressure damage and local quality improvement (QI) action. ***Impact:*** New approach for some trusts; likely impact is higher reported numbers.
	Action lead by December 2018: Trust boards to review their current practice and implement changes as required to local reporting.
21. Reporting DTIs **should** be incorporated into local monitoring systems.	***Rationale:*** To reduce variation in reporting across trusts. To support timely identification of pressure damage and local QI action. ***Impact*:** New approach for some trusts; likely impact is higher reported numbers.
	Action lead by December 2018: Trust boards to review their current practice and implement changes as required to local reporting.
22. Reporting of new pressure ulcers (POA), observed during the skin assessment undertaken on admission to that service, **should** be incorporated into local monitoring systems.	***Rationale*:** New approach to ensure capture of all pressure damage (Category 2 and above), regardless of attribution. ***Impact*:** Likely impact is higher reported numbers.
	Action lead by December 2018: Trust boards to review their current practice and implement changes as required to local reporting.

Recommendation	Rationale / likely impact
23. The number of patients with a pressure ulcer **should** be incorporated into local monitoring systems.	***Rationale*:** This will include reporting a greater range of pressure damage categories as previously outlined, to reduce variation of reporting in practice. ***Impact*:** Likely rise in reported numbers, as previously outlined.
	***Action lead by December 2018*:** Trust boards to review their local practice as previously outlined.
24. All pressure ulcers, including those that are considered avoidable and unavoidable, should be incorporated in local PU monitoring.	***Rationale:*** Consistent with Recommendation 10; avoidable and unavoidable harm will no longer be considered in practice, to help focus on learning and any lapses in care. ***Impact:*** This will have moderate impact on local reporting and national reporting as numbers reported will increase.
	Action lead by December 2018: As Recommendation 10, **NHS Improvement/NHS England** to review all relevant documents, including commissioning approaches, to support implementation of this recommendation. ***Trust boards:*** To review local documentation and implement the change in practice, to educate all staff about the changes in practice.
25. Moisture-associated skin damage (MASD) should be counted and reported in addition to pressure ulcers.	***Rationale*:** To capture skin damage that is currently reported inconsistently. To help identify the clinical problem with individual trusts and QI action that needs to be taken. ***Impact:*** Likely impact is higher reported numbers of incidents; new category needed for local monitoring systems.
	Action lead by December 2018*: NHS Improvement** to review impact on national data systems with NHS Digital. ***Trust boards: to review their local policies and practice.

Recommendation	Rationale / likely impact
26. Where skin damage is caused by a combination of MASD and pressure, it will be reported based on the category of pressure damage.	***Rationale:*** This will clarify the requirement to report pressure ulcers where MASD is also present. ***Impact*:** Low impact on reported numbers.
	Action lead by December 2018 – trust boards: To review their local policies and practice.
27. Unstageable and DTI ulcers should be reviewed by a clinician with appropriate skills on a weekly basis to help identify a definitive PU category and change the category as required.	***Rationale:*** This is a practice recommendation that should improve the accurate reporting of pressure damage in a more timely way. ***Impact*:** This may affect specialist teams' clinical workload.
	***Action lead by December 2018*: Specialist tissue viability nurse teams** to review current service approach, to support education of more generalist staff in practice.
28. Only pressure ulcers that meet the criteria for a Serious Incident (SI) should be reported to the clinical commissioning group.	***Rationale:*** To reduce variation in current local reporting approaches and the development of a consistent database at national level. To support organisation learning with each SI reported. ***Impact*:** Likely impact on local reporting agreements.
	***Action leads by December 2018*: NHS Improvement/NHS England** to promote a consistent approach across providers and commissioners.

Recommendation 29: From the national Stop the Pressure programme's work, we recommend no change to the definition of an incident and no amendment to the *Serious Incident framework: supporting learning to prevent reoccurrence* (March 2015), which remains the overarching policy.

NHS Safety Thermometer

The NHS Safety Thermometer database is currently the only national database for pressure ulcers. There are approximately 8.4 million data points within the dataset, which has been in use since 2011. Developed for the NHS by the NHS as a point-of-care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm. It can be used alongside other measures to gauge local and system progress in providing a harm-free care environment for patients.

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm-free' during their working day: for example, at shift handover or during ward rounds. This is not limited to hospitals; patients can experience harm at any point in a care pathway, and the NHS Safety Thermometer helps teams in a wide range of settings – from acute wards to a patient's own home – to measure, assess, learn and improve the safety of the care they provide.

Recommendation 30:

- **NHS Safety Thermometer data collection should continue as a monthly point prevalence tool in all trusts to aid understanding of pressure ulcer and other harms in a local clinical setting.**
- **We recommend that all trusts should undertake the NHS Safety Thermometer measurement each month to support quality improvement at individual department level.**
- **Data generated should be with other local data sources – eg NRLS – to understand the harm profile in any clinical area.**

Table 3 below shows the high level plan for the national implementation of the revised framework. This is due to be completed by the end of March 2019. By then all trusts should have fully implemented all recommendations and report against them from 1 April 2019, with national databases and policies appropriately supporting this framework in practice.

Table 3: High level implementation approach 2018/19

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Finalisation of governance and approval of recommendations in practice across all national stakeholders. Trusts prepare to amend local policies and educate staff as required.	Communication to all key stakeholders about revised approach, including all trusts and relevant commissioning bodies. Workshops/WebEx on learning from incidents.	Trusts required to complete preparations for implementing revised framework in relation to their local measurement approaches. Review of national contract completed (where relevant).	Shadow reporting for all trusts using revised framework. Review of data at a national level to understand impact before national rollout from April 2019.

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