

In this article...

- Evidence of discrepancies between trusts in pressure ulcer measurement and reporting
- Current international guidance on pressure ulcer classification
- NHS Improvement recommendations on pressure ulcer definition and measurement

New guidance on how to define and measure pressure ulcers

Key points

Pressure ulcer occurrence is an indicator of care quality

There are disparities between trusts and some under-reporting due to the different ways trusts measure pressure ulcers

NHS Improvement has published new guidance on the definition and measurement of pressure ulcers

A consensus exercise involving a range of stakeholders was used to produce the new guidance

The guidance encompasses 30 recommendations, including an agreed definition of pressure ulcers

Nurses and midwives are in a strong position to provide leadership in this area

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Abstract The occurrence of pressure ulcers is an indicator of care quality. In recent years, there has been considerable effort to reduce the number of pressure ulcers and related harm, but this effort has been offset by disparities between trusts in the way they define, measure and report pressure ulcers. As part of the Stop the Pressure programme, new guidance on pressure ulcer definition and measurement in England has been issued by NHS Improvement after a consensus-seeking exercise involving a large range of stakeholders. The guidance will be rolled out nationally from April 2019. This article discusses the guidance, why it was needed and how it was developed.

Citation Fletcher J, Hall J (2018) New guidance on how to define and measure pressure ulcers. *Nursing Times*; 114: 10, 41-44.

NHS Improvement has recently published revised recommendations for the definition and measurement of pressure ulcers (NHSI, 2018) designed to ensure a more consistent approach across trusts in England. Devised as part of the national Stop the Pressure programme led by NHSI, they set out for the first time an agreed definition of a pressure ulcer in England. The guidance was developed in response to concerns that there are high levels of under-reporting and that systems used locally, regionally and nationally to monitor harm from pressure ulcers lack consistency.

This article explains the background, development and forthcoming implementation of the guidance, which aims to support local quality improvement programmes through consistent reporting and learning from incidents.

Reducing harm

The occurrence of pressure ulcers in healthcare remains a challenge for care providers, as it is rightly seen as an

indicator of quality of care. A number of initiatives have been introduced in recent years in the NHS in England to reduce avoidable harm from pressure ulcers. These include prevalence reporting through the Safety Thermometer (Box 1) and incidence reporting through an incident reporting system (IRS). While these initiatives have been implemented across England, a lack of comprehensive guidance – for example, on the categories of pressure ulcers or classification system to use – has led to concerns about variation in local implementation and a subsequent lack of consistency in reporting.

In recent years, a significant and concerted effort has been made to reduce the number of pressure ulcers, which has resulted in a reduction. Unpublished data for May 2018 shows rates of 4.5% (all pressure ulcers) and 0.9% (new pressure ulcers) among all patients, as measured by the Safety Thermometer, compared with 7% and 1.7% in 2012 (Health and Social Care Information Centre, 2014). However, these figures have been relatively static since 2015, indicating a slowing down of quality improvement.

Box 1. Safety Thermometer

The NHS Safety Thermometer (www.safetythermometer.nhs.uk) provides the only national database of pressure ulcers; in use since 2011, it contains approximately 8.4 million data points. Developed as a point-of-care survey instrument, it provides a 'temperature check' on harm, and can be used alongside other measures to gauge local and system progress in providing a harm-free care environment.

The Safety Thermometer allows teams to measure the proportion of patients who are 'harm-free', for example during ward rounds or at shift handover. Its use is not limited to hospitals: patients can experience harm at any point in the care pathway, and the thermometer helps teams in a wide range of settings – from acute wards to patients' homes – to measure, assess and improve the safety of the care they provide.

Adapted from NHSI (2018)

In November 2016, NHSI launched the national Stop the Pressure campaign to drive and coordinate a renewed effort to reduce the number of pressure ulcers.

Disparities in measurement

To accurately measure any improvements, it was essential to ensure the measurement tools used were robust. Anecdotal feedback from clinicians suggested there were clinically significant differences between organisations in the way pressure ulcers were measured and reported.

A national survey undertaken in England investigating the language used when reporting (Fletcher, 2012) had previously identified considerable disparity (Fig 1). Among 145 responding organisations:

- Twenty-five were using an outdated version of the pressure ulcer classification system instead of the one currently recommended (Box 2);
- Fewer than 40 used the 'deep tissue injury' (DTI) category;
- Fewer than 63 used the 'unstageable' category.

These shortcomings would have had affected both the overall number of ulcers reported and the numbers per category,

precluding any comparison between organisations. The same survey also showed variations in the way organisations acted on their findings, with differences regarding which category of pressure ulcer would trigger a root cause analysis or a serious incident report.

Evidence of disparities was also found in national prevalence studies in Wales (Fletcher et al, 2015), which showed that 18% of the pressure ulcers identified during skin screening had not been previously identified by ward staff and that a further 18% had been incorrectly reported (incorrectly categorised either as something else, or as pressure ulcers when they were moisture lesions or other wounds of different aetiology).

Audit of monitoring systems

Based on the work of Fletcher (2012) and the outcomes of debate within the East of England Tissue Viability Group, the Tissue Viability Society (TVS) called a consensus meeting to attempt to solve some of the issues; a report (Dealey et al, 2012) followed, but little changed as a result.

In 2015, following petitioning from the East of England Tissue Viability Group, the NHS England safety team commissioned

the TVS to undertake a project to further measure the extent of disparities and inaccuracies in pressure ulcer reporting. Monitoring systems were audited in 24 organisations in two audits (Coleman et al, 2016; Smith et al, 2016).

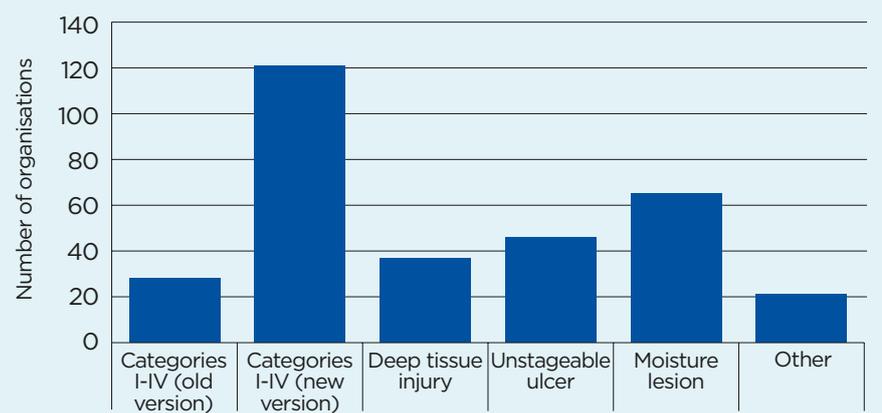
Smith et al (2016) found:

- Significant under-reporting via the Safety Thermometer; their audit identified 160 (7.1%) patients with a pressure ulcer, compared with 105 reported (4.7%);
- Significant under-reporting via an IRS; their audit identified 189 (8.4%) patients with a pressure ulcer, compared with 135 (6.0%) according to the IRS; approximately half the patients (101/189, 53.4%) identified by the audit had also been identified by the IRS; however, 34 of those identified in the IRS were not in the audit, which found that 11 had wounds with different aetiologies and 23 had healed pressure ulcers or other types of wounds.

Coleman et al (2016), who focused on how data was captured, found that different organisations used different classification systems. There had been little change since the 2012 survey (Fletcher, 2012), with only five out of 24 organisations (20.8%) saying they used all six pressure ulcer categories (Box 2). There were inconsistencies in the reporting of category I and II ulcers and of device-related ulcers, all of which could have influenced total numbers. Coleman et al concluded there was substantial variation in the local implementation of national policy, evidenced by the differences in definitions and data collection processes.

From both audits, it was clear that it was not possible to compare pressure ulcer prevalence and incidence rates between (and sometimes within) organisations.

Fig 1. Disparities in pressure ulcer categories used by 145 organisations



Source: Fletcher (2012)

Box 2. Current classification system of pressure ulcers

According to the latest international guidelines, pressure ulcers should fall into one of the following six categories:

- Category I – non-blanchable erythema
- Category II – partial thickness skin loss
- Category III – full thickness skin loss
- Category IV – full thickness tissue loss
- Deep tissue injury (DTI) – depth unknown
- Unstageable (US) ulcer – depth unknown

Adapted from NPUAP et al (2014)

Table 1. Summary of the final recommendations^a

Recommendations relating to the definition of pressure ulcers

1. We should use the term 'pressure ulcer'
2. A pressure ulcer should be defined as: "Localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a device), resulting from sustained pressure (including pressure associated with shear). The damage can present as intact skin or an open ulcer and may be painful"
3. A pressure ulcer that has developed due to the presence of a device should be referred to as a 'device-related pressure ulcer'
4. The 2015 NPUAP 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"
5. A pressure ulcer that has developed at the end of life due to 'skin failure' should not be referred to as a 'Kennedy ulcer'
6. Organisations should follow the current classification system recommended in international guidelines,^b incorporating categories I, II, III and IV
7. Organisations should follow the current classification system recommended in international guidelines,^b incorporating DTI
8. Organisations should follow the current classification system recommended in international guidelines,^b incorporating unstageable ulcers
9. The definition of a POA should be that it is observed during the skin assessment undertaken on admission to a service
10. The Department of Health and Social Care's definition of avoidable/unavoidable **should not** be used
11. The definition of a new pressure ulcer within a setting is that it is first observed within the current episode of care
12. The term 'category' should be used from October 2018 at a national level (in national reporting/policy documents)
13. Local organisations should, from October 2018, work towards using the term 'category' in clinical practice and local reporting/policy documents, with full implementation by the end of October 2018

Recommendations relating to the local and national measurement of pressure ulcers

14. The '72-hour rule' should be abandoned
15. Reporting of all pressure ulcers grade 2 and above on admission (POA) (observed in the skin assessment on admission to that service) should be incorporated into local monitoring systems.
16. Device-related pressure ulcers should be reported and identified by the notation of (d) after the report - for example, 'category II pressure ulcer (d)' - to allow their accurate measurement
17. Kennedy ulcers should not be measured separately
18. All reports should identify patients using their NHS number, not the hospital number, to help reduce duplication of reporting
19. Reporting pressure ulcers of category II and above should be incorporated into local monitoring systems
20. Reporting unstageable pressure ulcers should be incorporated into local monitoring systems
21. Reporting DTIs should be incorporated into local monitoring systems
22. Reporting of new POAs should be incorporated into local monitoring systems
23. The number of patients with a pressure ulcer should be incorporated into local monitoring systems
24. All pressure ulcers, including those that are considered avoidable or unavoidable, should be incorporated into local monitoring
25. MASD should be counted and reported in addition to pressure ulcers
26. Where skin damage is caused by a combination of MASD and pressure, it will be reported based on the category of pressure damage
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
28. Only pressure ulcers that meet the criteria for a serious incident should be reported to commissioners

Recommendation from Stop the Pressure

29. We recommend no change to the definition of an incident and no amendment to the *Serious Incident Framework: Supporting Learning to Prevent Reoccurrence* (NHS England, 2015), which remains the overarching policy

Recommendation relating to the NHS Safety Thermometer

30. ● NHS Safety Thermometer data collection should continue as a monthly point prevalence tool in all trusts to aid understanding of pressure ulcers and other harms in a local clinical setting
 - All trusts should undertake the NHS Safety Thermometer measurement each month to support quality improvement at individual department level
 - Data generated should be cross-referenced with other local data sources (for example, National Reporting and Learning System) to understand the harm profile in any clinical area

■ Responsibility at both national and local level ■ Responsibility at national level ■ Responsibility at local level

^aA full version of this table, including rationales, impacts and action leads responsible for implementation accompanies the online version of this article at bit.ly/NTPUGuidance. ^bThe international guidance is: National Pressure Ulcer Advisory Panel et al (2014)

DTI = deep tissue injury; MASD = moisture-associated skin damage; NPUAP = National Pressure Ulcer Advisory Panel; POA = pressure ulcer on admission

Revised framework

In January 2017, Stop the Pressure set up two small 'task and finish' groups with the aim of clarifying definition and measurement. They comprised representatives from tissue viability, nurse directors, academia, NHS England and the NHSI Stop the Pressure team. Their objectives were to make recommendations for a revised national framework that would support consistency in the definition and measurement of pressure ulcers in practice.

The groups outlined a draft framework based on evidence and expert opinion, then convened a national consensus meeting so that a large number of people could participate. Invitations were sent via regional tissue viability nurse networks and to other stakeholders such as hospice nurses. The draft framework and supporting information were circulated to all attendees before the meeting, which took place in May 2017.

Seeking consensus

The meeting was attended by 137 people from a range of backgrounds (Box 3). Following a presentation of the 29 draft statements and the information on which these were based (which included both information supporting and disagreeing with the statements), attendees were asked to vote electronically on each statement using a rating scale of 1-9 (where 1 was 'strongly agree' and 9 'strongly disagree').

Votes of 1-3 were taken to indicate agreement, 4-6 to indicate 'no view'; and 7-9 to indicate disagreement. If one of these three categories gained $\geq 70\%$ of votes, it was considered that consensus had been achieved on that statement. If there were $\geq 70\%$ of 1-3 votes, the statement was accepted. The voting saw 14 statements accepted.

The remainder were revisited by the task and finish groups and their wording reviewed to reflect key points raised in the consensus discussion in the first round. Following advice from academics experienced in consensus methodology, a second series of revised statements was prepared for all questions/topic areas that had not achieved consensus. To widen the pool of participants, the second round of voting was done through an online survey advertised via the regional tissue viability nurse groups and the newly formed tissue viability nurses Facebook group.

A total of 244 people participated; they had access to a background document outlining the key points from the consensus process, which was flagged up as essential to read before voting.

Box 3. Background of consensus meeting attendees

- Tissue viability nurses
- Directors of nursing
- District nurses
- Community matrons
- Infection prevention and control nurses
- Practice development staff
- Hospice staff
- Academic staff (teaching)
- Academic staff (research)
- Quality leads
- Manual handling leads
- Continence leads
- Chief nurses
- Directors of quality
- Pathway leads
- Nurse advocates

Following the second round of voting:

- Three revised statements were agreed;
- Two further revised statements within 2% of the 70% threshold were also determined as having been agreed.

The task and finish groups and Stop the Pressure team discussed whether it would be worth holding a third round of voting to try to achieve consensus on the remaining 10 statements, but decided these would be unlikely to reach the 70% threshold. They, therefore, decided the task and finish groups would discuss whether any further revisions of the remaining statements should be undertaken, and ultimately determine a final set of recommendations.

Implementation plan

The 30 final recommendations (Table 1) underwent governance checks at NHSI and were published in June 2018 (NHSI, 2018). For recommendations 1-28, the guidance also outlines rationale, likely impact and actions; these are presented in the full version of Table 1 included with the online version of this article (Bit.ly/NTPUGuidance). For most of the recommendations the impact is likely to be minimal or low.

A plan and a communications strategy have been developed to support implementation of the recommendations in practice and, it is hoped, start standardising how pressure ulcers are defined, measured and reported. National roll-out is planned to start in April 2019, preceded by the following steps (NHSI, 2018):

- Quarter 1: finalisation of governance and approval of recommendations in practice across all national stakeholders; trusts prepare to amend

local policies and educate staff as required; revised framework tested in shadow form by a range of trusts;

- Quarter 2: communication to all key stakeholders about revised approach, including all trusts and relevant commissioning bodies; workshops and/or online training on learning from incidents;
- Quarter 3: trusts complete preparations for implementing revised framework in relation to their local measurement approaches; review of national contract completed where relevant;
- Quarter 4: shadow reporting using revised framework by all trusts; review of data at a national level to understand impact before national roll-out from April 2019.

Conclusion

The occurrence of pressure ulcers is a measure of the quality of care. However, if they are to be identified and reported in a consistent way, it is imperative that there are clear definitions of what needs to be measured and how measurement needs to be done. For a long time, clinicians have been aware of, and tried to quantify, the discrepancies to provide a baseline for improvement, but to date they have been unsuccessful. It is hoped that this system-wide approach led by NHSI will have the necessary influence on clinical practice, so it can help clinicians deliver high-quality pressure ulcer care, alongside standardised educational and quality improvement approaches. **NT**

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