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

Table 1. **The final recommendations with rationales, impacts and actions**

Recommendations relating to definition of pressure ulcers	
Recommendation	**Rationale/likely impact/action leads**
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 EPUAP 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: "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 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 device should be referred to as a 'device-related pressure ulcer'	**Rationale** New definition to be used in practice, which will reflect the level of pressure ulcers caused by devices as these are currently under-reported **Impact** This new definition will need to be incorporated into national and local incident reporting systems
	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, for example the National Reporting and Learning System **Trust boards** to review their local policies and reporting approaches, and implement the new definition in practice
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"	**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 the 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** Review local policies and reporting approaches, and implement the new approach in practice
6 Organisations should follow the current classification system recommended in international guidelines*, incorporating categories I, II, III and IV	**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** to amend their local policies where relevant

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7 Organisations should follow the current classification system recommended in the international guidelines*, incorporating DTI	**Rationale** Will lead to the recording of DTI, which is currently not recorded in some trusts, and support early clinical intervention where required **Impact** 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 classification system recommended in international guidelines*, incorporating unstageable ulcers	**Rationale** Will lead to the recording of unstageable ulcers **Impact** 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 POA should be that it is observed during the skin assessment undertaken on admission to a 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** amend relevant national documents. **NHS Digital** to consider inclusion in Hospital Episode Statistics **Trust boards** to amend local policies and implement the revised approach
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 and safeguarding referrals as the existing approach is embedded in practice
	Action leads 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 **NHS Improvement** to work with the chief social worker to review the safeguarding adults protocol **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
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 end October 2018	**Rationale** To support the consistent use of terminology within policy documents **Impact** Updating where relevant local policy documents
	Action lead by October 2018 **Trust boards** to review local policy documents

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Recommendations on local and national measurement of pressure ulcers	
Recommendation	**Rationale/likely impact/action leads**
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 POA. 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 leads 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) (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
	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 – for example, 'category II pressure ulcer (d)' – to allow their accurate measurement	**Rationale/impact** The rationale/impact for the reporting of 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 the 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 pressure ulcer numbers as traditionally Kennedy ulcers were not reported in pressure ulcer datasets
	Action lead 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 patients 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
19 Reporting pressure ulcers of category II and above 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

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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 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 quality improvement 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 observed during the skin assessment undertaken on admission to a service (POAs) should be incorporated into local monitoring systems	**Rationale** New approach to ensure capture of all pressure damage (category II 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
23 The number of patients with a pressure ulcer should be incorporated into local monitoring systems	**Rationale** 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** Review local practice as previously outlined
24 All pressure ulcers, including those that are considered avoidable or unavoidable, should be incorporated in local 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 leads by December 2018 **NHS Improvement/NHS England** to review all relevant documents, including commissioning approaches, to support implementation of this recommendation **Trust boards** to review their local documentation and implement the change in practice, to educate all staff about the changes in practice
25 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 quality improvement action that needs to be taken **Impact** Likely impact is higher reported numbers of incidents; new category needed for local monitoring systems
	Action leads by December 2018 **NHS Improvement** to review impact on national data systems with NHS Digital. **Trust boards** to review their local policies and practice.
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** 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** A practice recommendation that should improve the accurate reporting of pressure damage in a more timely way **Impact** 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

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28 Only pressure ulcers that meet the criteria for a serious incident should be reported to commissioners	**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 serious incident reported **Impact** Likely impact on local reporting agreements
	Action lead by December 2018 **NHS Improvement/NHS England** to promote a consistent approach across providers and commissioners
Recommendations 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 ulcer 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	

* The international guidance is: National Pressure Ulcer Advisory Panel et al (2014) *Prevention and Treatment of Pressure Ulcers: Clinical Practice Guidelines* (2nd edn). **Bit.ly/PressureUlcers2014Guidance**

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