NHS Improvement

Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS

This guide will help tissue viability nurses and pressure ulcer prevention leads work with their risk or governance teams to embed the changes required by the *Pressure ulcers: revised definition and measurement* framework in their local incident reporting system, while maintaining correct connectivity to the National Reporting and Learning System (NRLS).

You should report pressure ulcers to the NRLS whether they developed during care provided by the your organisation or were present on admission. They should always be reported with the accurate degree of harm, whichever group they belong to. We acknowledge that this may cause a shift in your data initially.

Pressure ulcer categories should not be linked to a specific preset degree of harm but should be assessed individually for degree of harm level.

This guidance only relates to NRLS reporting; please see the Serious Incident Framework and associated FAQs for when pressure ulcers may need to be reported as Serious Incidents (and note the advice in Section 8 of the *Serious Incident Framework – frequently asked questions* that there are **no** national requirements for certain categories to be reported as SIs).

Please replicate Table 1 (see below) in your local risk management system and match the NRLS codes to the list as shown. The NRLS team will not review this listing change, and the responsibility for accuracy lies with the reporting organisation.

Table 1 is a suggested incident type subcategory/cause list for use with your local risk management system. Related NRLS coding has been included. The list takes into account the *Pressure ulcers: revised definition and measurement* guide's recommendations, including:

- 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' (Recommendation 3).
- The National Pressure Ulcer Advisory Panel's 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" (Recommendation 4).
- A pressure ulcer that has developed at end of life due to 'skin failure' **should not** be referred to as a 'Kennedy ulcer' (Recommendation 5).
- The definition of a pressure ulcer on admission **should** be that it is observed during the skin assessment undertaken on admission to that service (Recommendation 9).
- The Department of Health and Social Care's definition of avoidable/unavoidable **should not** be used (Recommendation 10).
- The definition of a new pressure ulcer within a setting is that it is first observed within the current episode of care (Recommendation 11).
- The term 'category' should be used from October 2018 at a national level (in national reporting/policy documents) (Recommendation 12).
- The '72-hour rule' **should** be abandoned (Recommendation 14).
- Reporting of **all** pressure ulcers **grade 2 and above** on admission (POA) (which is observed in the skin assessment on admission to that service) **should** be incorporated into local monitoring systems (Recommendation 15).
- Reporting unstageable pressure ulcers **should** be incorporated into local monitoring systems (Recommendation 20).

- Moisture-associated skin damage (MASD) should be counted and reported in addition to pressure ulcers (Recommendation 25).
- Where skin damage is caused by a combination of MASD and pressure, it will be reported based on the category of pressure damage (Recommendation 26).

Where there is failure of or lack of medical devices for preventing pressure ulcers, but **no pressure ulcer** has occurred, these incidents should be reported to the NRLS under a different listing to those below (eg 'medical equipment unavailable'). Ensure local reporters do not inappropriately select 'medical device related pressure ulcers' in your local system to report pressure ulcers that are related to failure or lack of a pressure-relieving device (eg mattress, etc) rather than ulcers caused by pressure from medical devices (eg masks or tubing).

Table 1: Suggested incident type subcategories/causes

Local system final tier (subcategory/cause 1) for incident type	NRLS coding	NRLS code description
Device-related pressure ulcer category 1 (d) developed or worsened during care by this organisation	ZI	Medical device – other
Device-related pressure ulcer category 2 (d) developed or worsened during care by this organisation	ZI	Medical device – other
Device-related pressure ulcer category 3 (d) developed or worsened during care by this organisation	ZI	Medical device – other
Device-related pressure ulcer category 4 (d) developed or worsened during care by this organisation	ZI	Medical device – other
Device-related deep tissue injury (d) developed or worsened during care by this organisation	ZI	Medical device – other
Device-related unstageable pressure ulcer (d) developed or worsened during care by this organisation	ZI	Medical device – other

Device-related pressure ulcer category 1 (d) present before admission to this organisation	ZI	Medical device – other
Device-related pressure ulcer category 2 (d) present before admission to this organisation	ZI	Medical device – other
Device-related pressure ulcer category 3 (d) present before admission to this organisation	ZI	Medical device – other
Device-related pressure ulcer category 4 (d) present before admission to this organisation	ZI	Medical device – other
Device-related deep tissue injury (d) present before admission to this organisation	ZI	Medical device – other
Device-related unstageable pressure ulcer (d) present before admission to this organisation	ZI	Medical device – other
Pressure ulcer category 1 developed or worsened during care by this organisation	ZG (DS1) Q0100 (DS2)	Implementation of care – other pressure ulcer
Pressure ulcer category 2 developed or worsened during care by this organisation	ZG (DS1) Q0100 (DS2)	Implementation of care – other pressure ulcer
Pressure ulcer category 3 developed or worsened during care by this organisation	ZG (DS1) Q0100 (DS2)	Implementation of care – other pressure ulcer
Pressure ulcer category 4 developed or worsened during care by this organisation	ZG (DS1) Q0100 (DS2)	Implementation of care – other pressure ulcer
Pressure ulcer deep tissue injury developed or worsened during care by this organisation	ZG (DS1) Q0100 (DS2)	Implementation of care – other pressure ulcer
Pressure ulcer unstageable developed or worsened during care by this organisation	ZG (DS1) Q0100 (DS2)	Implementation of care – other pressure ulcer
Pressure ulcer category 1 present before admission to this organisation	ZG (DS1) ZQ (DS2)	Implementation of care – other PU – other
Pressure ulcer category 2 present before admission to this organisation	ZG (DS1) ZQ (DS2)	Implementation of care – other PU – other

Pressure ulcer category 3 present before admission to this organisation	ZG (DS1) ZQ (DS2)	Implementation of care – other PU – other
Pressure ulcer category 4 present before admission to this organisation	ZG (DS1) ZQ (DS2)	Implementation of care – other PU – other
Pressure ulcer deep tissue injury present before admission to this organisation	ZG (DS1) ZQ (DS2)	Implementation of care – other PU – other
Pressure ulcer unstageable present before admission to this organisation	ZG (DS1) ZQ (DS2)	Implementation of care – other PU – other
Moisture-associated skin damage (MASD) (incontinence-associated) developed during care by this organisation	ZG (DS1) ZG (DS2)	Implementation of care – other
Moisture-associated skin damage (MASD) (not incontinence-associated) developed during care by this organisation	ZG (DS1) ZG (DS2)	Implementation of care – other
Moisture-associated skin damage (MASD) (incontinence-associated) present before admission to this organisation	ZG (DS1) ZG (DS2)	Implementation of care – other
Moisture-associated skin damage (MASD) (not incontinence-associated) present before admission to this organisation	ZG (DS1) ZG (DS2)	Implementation of care – other

For some subcategories/causes, the NRLS codes provided differ depending on whether your local risk management system is set to NRLS dataset 1 (DS1) or NRLS dataset 2 (DS2). The codes are labelled in Table 1 accordingly. If you require guidance on how to make these changes in your local risk management system, please contact your local risk management system vendor for advice. Ulysses coding changes should be made on the maintenance table as in Table 1. Datix IN05 (incident type) coding requires three-tier selection to obtain the required codes. Table 2 (below) provides the recommended tiers to select. Please contact your vendor for assistance if required. Datix users of the CCS1 or CCS2 fixed IN05 (incident type) lists should contact their vendor for advice.

Table 2: Recommended tiers

Stage of care	Detail	Adverse event	NRLS code
Medical device/equipment	Medical device/equipment	Medical device/equipment – other	ZI
Implementation of care or ongoing monitoring/review	Implementation of care or ongoing monitoring/review	Implementation of care or ongoing monitoring/review – other	ZG
Implementation of care or ongoing monitoring/review	Pressure ulcer/ decubitus ulcer (ulcer)	Pressure ulcer acquired during NHS care	Q0100
Implementation of care or ongoing monitoring/review	Pressure ulcer/ decubitus ulcer (ulcer)	Pressure ulcer other	ZQ

While small amendments for local clarity to these suggested incident groups are acceptable (eg locally you may wish to refer to 'this trust' rather than 'this organisation') it would be unacceptable to bring back any local incident categorisation that is attempting to bypass the new definitions. It is particularly important that pressure ulcers are not divided into 'preventable' and 'unpreventable' or any synonym for those terms.

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