Pressure ulcers: definition and measurement: summary of responses to feedback

November 2018

In September 2018 we published a revised version of Pressure ulcers: revised definition and measurement with minor changes to Sections 10, 15 and 27 based on feedback from the frontline.

The table below outlines our responses to other questions we received. We have themed them and posed most of the questions as summaries of several queries for ease of reading.

Topic	Questions raised/further clarification	
Moisture-associated skin damage (MASD)	**What level/severity of damage would be reported, and which body sites were included?** It is anticipated that all levels of severity and body sites will be reported. **Why had a definition not been provided and did the document just refer to incontinence associated damage (IAD)?** Although there was a definition of MASD in the original consensus, it was not agreed. The document refers to all causes of moisture damage. **Where was the MASD to be reported and should this trigger a Datix report?** The aim of this change in reporting profile is to encourage local quality improvement. Individual trusts should report all appropriate incidents on their local reporting system to support organisational learning. **Reporting of nappy rash in infants**. This should be reviewed locally by the trust. We would not anticipate this would be routinely reported.	

Removal of avoidable and unavoidable terms	**Organisations queried how, without the terms 'avoidable' and 'unavoidable', they would demonstrate how they are providing good care to their commissioners.** The approach is consistent with that of all patient safety harms. A strong investigation and review process will highlight care provision, including any aspects of learning that need to be taken forward and good practice. The findings should be shared within the trust and with other key stakeholders, such as commissioners. The terms should not be replaced by different terms with similar meanings.
Pressure ulcers at end of life	**There were queries about the scope of 'Kennedy ulcers' and if it was possible still to use the term 'skin changes at life's end (SCALE)'.** 'Kennedy ulcers' are butterfly-shaped ulcers at the sacrum, this is the term that will cease to be used. End of life skin failure should be determined on an individual case basis and if necessary via root cause analysis. SCALE should only apply where pressure ulcers occur when death is imminent.
Deep tissue injury (DTI)	**There was a query about delayed manifestation of DTI**. Most research from the USA suggests that the DTI will evolve or resolve within 72 hours. Each individual incident should be reviewed using root cause analysis. **DTI monitoring: is this for all DTI (inherited and acquired) and is there a recommendation about sharing the information with providers where it occurred?** Yes, for all DTI. **Several questions referred to the lack of coding in the various national systems for both DTI and unstageable:** As part of our current implementation plan we are contacting all relevant organisations to make changes across a range of reporting systems. This is a key step to support the changes in reporting from April 2019. Further information will be provided once this work has been completed. **Queries were raised about how a DTI would be categorised once it evolved:** Once a DTI evolves it would be categorised as the category it becomes. If it resolves, the incident report would be amended accordingly. Research from the USA suggests that the evolution is usually evident within 72 hours. If the evolution is to unstageable, report as unstageable and amend once the category is evident.
Device-related pressure ulcers (DRPUs)	**Where should the notation for device-related pressure ulcers be recorded - in reports, patient records?** Wherever the pressure ulcer is recorded. **Device-related pressure damage: do these need to be reported separately or counted in our numbers in total?** Counted in the total.

	There was a query about the current absence of coding in systems: Response as above. **There was inconsistency between the terminology used in the document with device related used in some places and medical device related used in others.** This has been amended. **Is there going to be a list of 'medical devices that should be included'?** No, there will not be a list. **A query has been raised about allocation of a category to DRPU.** Where this is possible it should be done as the original recommendation, eg Category 2 PU (d). Where it is not possible, eg on mucosa or areas such as ears or nares where normal tissue types are not present, it should just be referred to as PU (d).
Counting	**In relation to counting numbers of patients, would a patient that develops a Category 2 one month that deteriorates the next month, be counted in both months (this is what we do currently)**? NLRS suggests you count it twice. **Similarly, if a patient develops two pressure ulcers in different body parts at different times of the month, does this counted as two patients?** Yes, because it is two harms. I**f a patient is admitted twice in one month with pressure damage, does this count as two patients?** If there is no change, it is just the one report; if there is change, it is two harms. **Can we clarify that we need to report (incident report) and locally monitor all pressure ulcers rather than patients with pressure ulcers.** There should be a clinical review of all patients with a pressure ulcer. **Queries were raised on Recommendations 15 and 19. Recommendation 15 asks for all pressure ulcers to be recorded on admission and Recommendation 19 suggests Category 2 and above should be incorporated into monitoring systems. Should all categories of pressure ulcer be recorded and monitored as otherwise you do not know the burden at Category 1 where we would suggest active management can prevent further deterioration.** Not currently a requirement in incident monitoring systems but we recommend you capture the data.

	Will Datix automatically be updated so that it links with the NRLS with the new PU categories and inclusion of the (d) for devices or should this be done locally? Yes, we hope to do this nationally.
In the community setting	**At the first community visit, any tissue damage present will be classed and reported as a pressure ulcer on admission (POA). At subsequent visits new tissue damage will be reported and classed as community acquired. However, the issue comes with patients who remain on caseloads; for instance for catheter care, where they may only receive a visit every 12 weeks, while others may be on a fortnightly schedule for bloods or palliative support. For people on schedules like this, district nurses would still report any pressure damage found, but up to now have been counting this as non-trust attributable, but is this the right thing? Has there been any mention of this or is there any guidance?** There is currently local variation in practice across community providers. Some organisations may admit and discharge patients in this scenario. Individual organisations should review and agree their practice with key stakeholders. **The document feels as though it has an acute provider bias:** The document is aimed at both acute and community providers equally. **In current practice a referral is received from the hospital, however a visit may not be required until a few days later. If at the first visit a pressure ulcer has developed would it still be classed as POA or would it be on caseload as the patient was referred a few days before? What is the timeframe between a referral and the need to do a skin assessment on admission?** If there is clear documentation from the hospital that there is no skin damage on discharge, then it would be attributable to community. If the patient is at increased risk, this should be communicated in the discharge summary and the patient would be seen sooner.
Other	**Please would you consider changing the term 'unstageable' in point 20**: This will remain in the document as it is an internationally recognised term. **Recommendation 15: What is meant by local monitoring system? Is this the same as incident reporting system, ie Datix? Or is local monitoring different to reporting?** The local system will be both for reporting and monitoring, Datix is one example of such a system.

	Recommendation 30: ST - Will clarification be sent out for ST collection about the new definition for new and old with the abolition of 72-hour rule? Please see previous comments about coding, we are working with the other national systems to make amendments **Page 5 refers to a consensus approach to the development of the document. Please can you advise who was involved for our future reference and evidence base?** Information has been provided within the document about the number and type of clinicians involved. Due to GDPR regulations we are not able to release the names of individuals as consent was not requested. Where individuals are named we were given permission to do so.