Healthcare Improvement Scotland



Scottish Patient Safety Programme

Pressure Ulcers

Measurement Framework

October 2026

NHS SCOTLAND

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Published October 2026

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1. How to use this Measurement Framework

Measurement is an essential part of improvement. It helps teams understand if the changes they are implementing are leading to better outcomes and improved care. This framework provides an overview of the three types of measurement used in improvement and outlines the data that participating teams are required to submit as part of the SPSP Pressure Ulcers programme. It also describes the measures associated with the SPSP Pressure Ulcers change package and provides guidance on how to collect, analyse and display data effectively.

The readiness for change toolkit can be used alongside this framework to help teams assess whether the conditions for change are in place, understand current practice against the Essentials of Safe Care, and identify priority areas for improvement. This can support teams in selecting and implementing the changes that are most likely to have the greatest impact in their local context.

This framework should be used in conjunction with the SPSP Pressure Ulcers driver diagram and change package. All measures are aligned to the relevant secondary drivers within the Essentials of Safe Care.

To learn more about measurement click on the link: The Improvement Journey - Measurement (TURAS)

1.1 Why measure

This measurement framework is intended to measure the impact of key changes that you want to make.

Measurement helps you to:

- recognise the variation that exists within your system and processes
- work out whether your changes are making an improvement, and
- help tell your improvement story.

To learn more about measurement, please see Measurement at the QI Zone on Turas.

1.2 Choosing measures

An improvement project should have a small family of measures that track the progress of the project over time. This should include:

- **Outcome measures:** to tell an NHS board, site or team whether the changes it is making are helping to achieve the stated aim. For example, measuring the rate of pressure ulcers per 1000 occupied bed days (OBD) over time.
- **Process measures:** to help the team understand whether key actions needed to achieve their local improvement aim are happening reliably. For example, the number of patients with a completed pressure ulcer risk assessment. Learning from these measures can help inform tests of change.
- **Balancing measures**: to understand possible unintended consequences of the work elsewhere in the system. For example, staff experience.

Outcome measures are routinely collected through the SPSP Adults in Hospital programme for national reporting.

Participating teams are expected to submit outcome data on pressure ulcers quarterly. From January 2027, NHS boards will be encouraged to submit at least one process measure alongside their outcome measure.

Participating NHS boards should select process and balancing measures that help them understand whether the changes they are making are leading to improvement. Boards may choose to use measures from this framework, or develop additional measures tailored to their local context. We encourage teams to seek local quality improvement support to develop alternative measures if required.

To learn more about measures click on the link: Developing your measures (TURAS)

1.3 How to measure

When planning your data collection consider:

- What data will you collect?
- Who will collect the data?
- When will you collect the data?
- How will you collect/ record the data?
- Any local information governance and /or clinical governance procedures you should follow.

To learn more about data collection click on the link: Data collection (TURAS)

1.4 Sampling

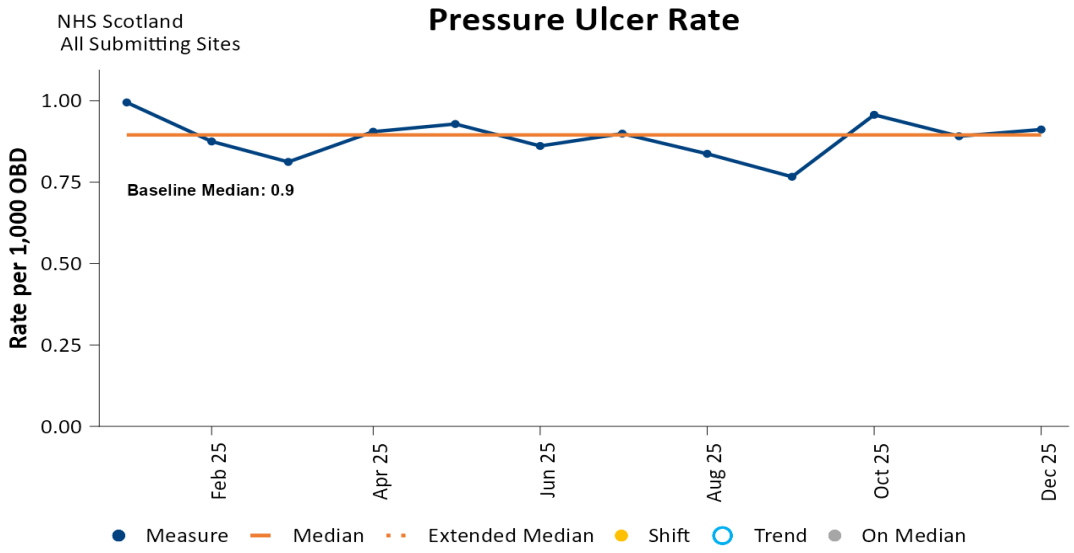
Measuring for improvement relies on small sample sizes, often referred to as 'just enough' data to learn from. When it is not possible to access a larger amount of data, it is suggested that a random selection of 5 records per week, giving 20 records per month will gather enough data.

1.5 Presenting data

Run charts are an excellent way to present your data to help you understand what is happening in your service. They are used to distinguish between random variation (variation that affects all processes, people and outcomes equally) and non-random variation, which could be due to the changes you have introduced.

The SPSP Adults in Hospital Team will issue a toolkit for outcome measures and process measures to NHS boards participating in the SPSP Adults in Hospital programme.

To learn more about presenting your data, please see Presenting data and Time Series Charts for Improvment at the QI zone on TURAS.



2. Pressure Ulcers Measures

Participating NHS boards should select a small family of measures that support their local improvement work. **One outcome measure** is routinely submitted through the SPSP Adults in Hospital national reporting process, alongside narrative progress reporting. **From January 2027**, NHS boards will be encouraged to submit at least **one process measure** alongside their outcome measure. Additional process and balancing measures may be selected to support local improvement priorities.

<table>
<tr><td colspan="2">Readiness for change and identifying opportunities for improvement
Readiness for change assessment tool
Engagement with adverse events team and/or regular case note review to identify opportunities for improvement</td></tr>
<tr><td>Outcome Measures</td><td>Pressure Ulcer Rate</td></tr>
<tr><td>Process Measures</td><td>A people-led approach to the planning and delivery of safe care
Percentage (%) of records with a locally agreed pressure ulcer risk assessment completed within 8 hours of admission and clearly linked to a person-centred prevention plan
Percentage (%) documented daily pressure ulcer risk reassessment clearly linked to a person-centred prevention plan
Percentage of patient, carers, families involved in person led planning for those with or at risk of developing a pressure ulcer
Effective and inclusive communication
Percentage compliance with individualised repositioning plans in place for those with pressure ulcers or at risk of developing a pressure ulcer
Leadership at all levels to support a culture of safety
Pressure ulcer reviews with evidence of shared learning with clinical teams
Safe clinical and care processes for pressure ulcer prevention, assessment, and treatment
Percent compliance with all elements of a SSKIN bundle
Percentage of patients with documented heel offloading plan in place</td></tr>
<tr><td>Balancing Measures</td><td>Pain management related to pressure ulcer care
Sleep disruption related to pressure ulcers</td></tr>
</table>

	• Count of concerns, complaints or issues relating to pressure ulcer prevention, development or management raised by patients, families or carers during the reporting period

2.1 Outcome Measures

Concept / Measure Name	What / How to measure	Data collection and reporting

Pressure ulcer rate
 	
Goal: Reduce the rate of acquired pressure ulcers in adult inpatients by 20% by March 2028
 	
Rate of new pressure ulcers per 1,000 Occupied Bed Days (OBD)
	Operational definition: This measure will show the rate of new pressure ulcers developed in the care setting for the month.
	
	Numerator: The total number of newly developed pressure ulcers identified in the care setting in the past month.
	
	Denominator: The total number of acute occupied beds in the care setting for the month
	
	Calcluation: (numerator ÷ denominator) x 1000, reported as pressure ulcers per 1000 OBD
	
	Inclusion criteria:
	
	• All newly developed pressure ulcers, acquired after admission or transfer in a care setting, of grade 2 or above including:
	  • combination lesions
	  • device related pressure ulcers
	  • suspected deep tissue injury, and
	  • ungradable pressure ulcer.
	
	Exclusion criteria:
	• Pressure ulcers present on day of admission or transfer in a healthcare setting and those where damage began prior to admission.
	• Grade 1 pressure ulcers.
	• Skin damage from moisture, for example, incontinence dermatitis.
		Data source: As per incident management system or local data collection tool.
		
		Reporting frequency: Monthly data points reported quarterly.
		
		Type of chart: Run chart
		
		For rare events: Data can be visualised using a days between chart.

2.2 Process Measures

A people-led approach to the planning and delivery of safe care

Concept / Measure Name	What / How to measure	Data collection and reporting
Percentage (%) of records with a locally agreed pressure ulcer risk assessment completed within 8 hours of admission and clearly linked to a person-centred prevention plan **Goal:** Process reliability at 95% or greater.	**Operational definition**: The number of patients reviewed who have a locally agreed risk assessment linked to person centred prevention plan within 8 hours of arriving at the care setting. **Numerator:** Total number of patients with a completed risk assessment linked to a person centred prevention plan within 8 hours of admission. **Denominator:** The total number of patients in the sample. **Percentage compliance**: (numerator ÷ denominator) x 100 **Inclusion criteria:** • All people admitted to the care setting/area during the month. **Exclusion criteria**: None	**Data source**: case notes, patient records, person's care record. **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. Include all patients if total numbers are less than 20. **Type of chart**: Aggregate data

Concept / Measure Name	What / How to measure	Data collection and reporting
Percentage (%)documented daily pressure ulcer risk reassessment clearly linked to a person-centred prevention plan **Goal:** Process reliability at 95% or greater	**Operational definition:** Compliance with risk assessments, completed at least daily, with evidence of re-assessment that is clearly linked to a prevention plan. **Numerator:** Total number of patients with a completed pressure ulcer re-assessment with prevention plan completed for each day of their stay in ward. **Denominator:** Total number of patients in the sample **Percentage compliance:** (numerator ÷ denominator) x 100 Distribute sampling across a range of days and shifts to reflect activity throughout the week. Select sample of five patients, reviewing for completed daily risk assessment (this can include the Scottish PPURA tool) during their admission. There must be evidence of a risk assessment being reviewed daily. **Inclusion criteria:** • All people admitted to the care setting/area during the month. **Exclusion criteria:** None	**Primary data source:** case notes, patient records, person's care record. **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. Include all patients if total numbers are less than 20. **Type of chart:** Aggregate data

Concept / Measure Name	What / How to measure	Data collection and reporting
Percentage of patient, carers, families involved in person led planning for those with or at risk of developing a pressure ulcer **Goal**: Process reliability at 95% or greater	**Operational definition**: Locally defined evidence of patient, carer or family involvement in pressure ulcer prevention planning. **Numerator**: The total number of people with a pressure ulcer prevention plan that includes evidence of patient, carer or family involvement. **Denominator**: The total number of people with a pressure ulcer prevention plan. **Percentage compliance**: (numerator ÷ denominator) x 100	**Primary data source**: Case notes, patient records, person's care record **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. Include all patients if total numbers are less than 20. **Type of chart**: Aggregate data

Effective and inclusive communication

Concept / Measure Name	What / How to measure	Data collection and reporting
Percentage compliance with individualised repositioning plans in place for those with pressure ulcers or at risk of developing a pressure ulcer **Goal**: Process reliability at 95% or greater	**Operational definition**: Compliance with all elements of a locally agreed repositioning plan. **Numerator**: The total number of patients assessed as at risk of developing a pressure ulcer or who have a pressure ulcer where a repositioning plan is in place. **Denominator**: the total number of patients with a pressure ulcer or at risk of developing a pressure ulcer. **Percentage compliance**: (numerator ÷ denominator) x 100 **Inclusion criteria:** All patients eligible for a repositioning plan as per locally defined criteria.	**Primary data source**: case notes, patient records, person's care record. **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. Include all patients if total numbers are less than 20. **Type of chart**: Aggregate data

Leadership at all levels to support a culture of safety

Concept / Measure Name	What / How to measure	Data collection and reporting
Pressure ulcer reviews with evidence of shared learning with clinical teams **Goal**: Process reliability at 95% or greater	Supports the shared learning with clinical staff delivering care to patients. Evidence of organisational learning. **Numerator**: Number of pressure ulcer reviews with evidence of shared learning with clinical teams. **Denominator**: Number of pressure ulcers reviews. **Percentage compliance:** (numerator ÷ denominator) x 100	**Data source**: Local incident management system. **Reporting frequency**: Monthly **Type of chart**: Run chart

Safe clinical and care processes for pressure ulcer prevention, assessment, and treatment

Concept / Measure Name	What / How to measure	Data collection and reporting
Percent compliance with all elements of a SSKIN bundle. **Goal**: Process reliability at 95% or greater	**Operational definition**: Compliance with all elements of a SSKIN bundle. SSKIN bundle is defined as: An evidence-based pressure ulcer prevention bundle comprising five key components: **Surface** (appropriate support surfaces), **Skin inspection** (regular assessment of skin integrity), **Keep moving** (repositioning and mobilisation), **Incontinence / moisture management**, and **Nutrition / hydration**. **Numerator**: The total number of people with a SSKIN bundle completed. **Denominator**: the total number of people with a pressure ulcer or at risk of developing a pressure ulcer. **Percentage compliance**: (numerator ÷ denominator) x 100 **Inclusion criteria:** As per locally agreed criteria for SSKIN bundle completion. **Note:** if a person is not eligible for one of the bundle elements for medical reasons and that exclusion is documented, that person is considered compliant for that element of the bundle.	**Primary data source**: case notes, patient records, person's care record. Vary data collection between the days of the week and shifts within a day. **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. Include all patients if total numbers are less than 20. **Type of chart**: Aggregate data

Concept / Measure Name	What / How to measure	Data collection and reporting
Percentage of patients with documented heel offloading plan in place. **Goal**: Process reliability at 95% or greater	**Operational definition**: Patients at risk of a heel pressure ulcer with a documented heel offloading plan in place. **Numerator**: The total number of people who have a heel offloading plan documented. **Denominator**: the total number of people eligible for a heel offloading plan as per locally defined criteria. **Percentage compliance**: (numerator ÷ denominator) x 100 **Inclusion criteria:** All people eligible for heel offloading as per locally defined criteria.	**Primary data source**: case notes, patient records, person's care record. **Reporting frequency:** Monthly sample of 20 e.g. sample 5 per week. Include all patients if total numbers are less than 20. **Type of chart**: Aggregate data

2.3 Balancing measures

Concept / Measure Name	What / How to measure	Data source
Pain management related to pressure ulcer care	Documentation of pain assessment and evidence of effective pain management for people with pressure ulcers.	Patient report, case notes, pain assessment documentation.

Concept / Measure Name	What / How to measure	Data source
Sleep disruption related to pressure ulcers	Evidence of patient reports of pressure ulcer related sleep disruption.	Case notes, patient records, person's care record.

Concept / Measure Name	What / How to measure	Data source
Concerns, complaints or issues relating to pressure ulcer prevention, development or management raised by patients, families or carers during the reporting period	Evidence of patient, carer or family concerns related to pressure ulcers.	Case notes, patient records, patient feedback systems, local complaints and concerns systems, local patient experience data

Published October 2026

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