NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Pressure ulcers

Date of Quality Standards Advisory Committee post-consultation meeting:
13 February 2015

2 Introduction

The draft quality standard for pressure ulcers was made available on the NICE website for a 4 week public consultation period between 12 December 2014 and 20 January 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 23 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

Stakeholders were also invited to respond to the following statement-specific question:

1. For draft quality statement 1: How, at an individual patient level, could a repeated risk assessment following a change in clinical status be measured?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Many stakeholders highlighted their support for this quality standard and agreed it reflected the key quality areas for improvement for pressure ulcers
- Some groups were particularly pleased the standard covered pressure ulcers in neonates, infants and children, not just adults
- Concerns were raised about the significant training and resource implications of the standard, which should be reflected in the commissioning specifications
- Some organisations noted that the standard was focused on prevention of pressure ulcers rather than management
- Concerns were raised that the standard was too hospital-focused and did not adequately address the needs of patients in the community

Consultation comments on data collection (question 2)

- Responses were positive about the possibility of data collection for the proposed measures if sufficient systems, structures and staffing levels were available
- Some stakeholders anticipated difficulties with data collection in the community and care homes, due to variety of staff and non-standard methods of data recording (clinical electronic systems vs. paper audit)
- Stakeholders highlighted a lack of specificity in some measures, with concerns regarding comparability and local interpretation

Consultation comments on supporting implementation (question 3)

- Stakeholders had the following suggestions to support implementation of this quality standard:
  - Availability of standardised risk assessment forms
  - Mandatory training of all staff
  - Appropriate staffing levels
  - A recommended number of Tissue Viability nurses per head
  - Frequent audits of different healthcare services (various options already exist)

- Focus on pressure ulcers at an executive level
- Promotion of services successful in achieving standards to encourage improvement
- A collaborative approach across the patient pathway between CCGs and local authorities
- Increased funding for the increased levels of administration needed
- Inclusion of patient representatives and groups in practice improvement
- Targeted and focussed education of patients and carers in the risks of pressure ulcers and the expectations of the care they should receive
- Questions could be included in the Safety Thermometer or a Root Cause Analysis for pressure ulcers
- Resources recommended from the Stop The Pressure website: http://nhs.stopthepressure.co.uk/

Summary of consultation feedback by draft statement

4.1 Draft statement 1

People admitted to hospital or a care home have a pressure ulcer risk assessment on admission that is repeated following a change in clinical status.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Stakeholders requested a timeframe following admission eg. within 6 hours in acute care, within 24 hours in a care home
- A stakeholder proposed splitting into two statements for admission and reassessment
- One group requested a minimum interval for reassessment to ensure gradual changes are not missed
- Stakeholders suggested the definition of "change in clinical status" should include: change in location and after interventional tests or procedures

Consultation question 4: How, at an individual patient level, could repeated risk assessment following a change in clinical status be measured?

Stakeholders made the following comments in relation to consultation question 4:

- "Change in clinical status" was considered vague, too healthcare-focussed for care homes and open to misinterpretation and/or excessive reassessment
  - A stakeholder suggested replacing with "daily reassessment" instead
- There should be documented evidence of a repeated risk assessment using the same validated tool as the initial assessment
- A change in clinical status could be identified through review of patient notes
- Use of NEWS (National Early Warning System) – national tool to identify if a patient's condition is changing
- A body chart would be needed for skin assessment and reassessment
- Concerns raised that initial assessment would be recorded but reassessment may only be recorded as free text within notes so difficult to measure

4.2 Draft statement 2

People identified at high risk of developing a pressure ulcer in any setting have a skin assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- A stakeholder felt there was overlap with statement 1 (risk assessment) - skin assessments should be repeated, especially when patients are transferred within and between institutions
- Some stakeholders requested that statements involving “patients at high risk” be changed to “patients at risk”
- An organisation felt that frequent, repeated skin assessments should be performed irrespective of change in clinical situation
- One stakeholder suggested change of wording to “…periodic skin assessment”
- Concerns were raised by stakeholders that a skin assessment may not always be appropriate/ possible in all care settings
- Stakeholders emphasised the equality and diversity implication in people with darker skin, as there can be difficulties in identifying and assessing skin damage in this group

4.3 Draft statement 3

People identified at risk of developing a pressure ulcer in any setting are advised to change their position frequently and offered help to do so if needed.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Requested change of wording from “are advised” to “receive advice”
- Consider linking this to Statement 2, as skin assessment should be undertaken at times of repositioning, to evaluate whether there is a need for more frequent repositioning
- Stakeholders highlighted that this statement overlaps with Statement 4 (giving information)
- Stakeholders thought this was a complex statement: consider dividing into two statements: people able to change position and those unable to do so
- Stakeholders highlighted that this statement does not address patients unable to understand prevention advice or those who are non-compliant, eg. those at risk due to neurological/cognitive impairment
- Concerns raised with data collection as this statement is for patients “at risk” – this could be all patients as no level of risk is specified
- One stakeholder thought “frequently” was too broad – the statement would be strengthened with the timeframe eg. at least every 4-6 hours
- Another group thought including timeframes in measures was unsafe and repositioning interval should be assessed and agreed with each patient
- Concerns raised with data collection, as the measures do not specify how advice should be given (verbal or written)
- Stakeholders commented that not all patients have ongoing district nursing care or carers to provide support during repositioning
- Stakeholders noted that this statement has cost implications for social care in terms of the frequency of packages of care

4.4 Draft statement 4

People identified at high risk of developing a pressure ulcer in any setting, and their carers, are given information on how to prevent them.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- This statement excludes patients at low/medium risk of pressure ulcers, or those with an existing pressure ulcer
- Some stakeholders requested that statements involving “patients at high risk” be changed to “patients at risk”
- One stakeholder thought the statement could be strengthened by specifying the provision of both verbal and written information
- For some patients, it may not be appropriate to give information eg. those with cognitive/neurological impairment, which should to be taken into account in the measures

4.5 Draft statement 5

People with an existing pressure ulcer or identified at high risk of developing one, in any setting, have access to pressure redistribution devices.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Stakeholders suggested replacing “have access to” with “are managed with”
- Some stakeholders requested that statements involving “patients at high risk” be changed to “patients at risk”
- Suggested adding timeframes to the measures for audit purposes:
  - Waiting time from requesting device until receiving one
  - Timeframe between identifying need and request for device
- Change of wording to “pressure redistributing or relieving device”
- Concerns were raised regarding patients at high risk, but not on District Nursing caseload not receiving devices, as there is no current service for equipment provision for this group

5 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Specific statement requested on nutritional screening for people of all ages with a pressure ulcer and use of appropriate nutritional supplements
- A statement on the best risk assessment tool for neonates (eg. Braden Q)
- Suggested statement on the risk of equipment/device-related pressure ulcers, in particular for patients in intensive care
- This standard does not to identify measures to elevate or float heels to prevent heel pressure ulcers or include the use of orthoses as pressure redistribution devices to prevent heel pressure ulcers
- Statements requested describing management practice to be avoided, to prevent patient harm:
    - Antibiotic use: do not offer systemic antibiotics to adults based only on positive wound cultures without clinical evidence of infection
    - Antibiotic use: offer systemic antibiotics to adults with a pressure ulcer if there are any of the following: clinical evidence of systemic sepsis, spreading cellulitis or underlying osteomyelitis

Appendix 1: Quality standard consultation comments table

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
British Association of Dermatologists	General	The 5 quality statements included are generally good Also, the *management* of pressure ulcers is a key area which has not been addressed and should be included if possible. If not, we suggest the title should be *prevention* of pressure ulcers.
Guys and St Thomas NHS Foundation Trust	General	It would be useful to have included a quality standard regards the equipment related pressure damage eg: pts in the ITU departments as there is little guidance regards this anywhere and is often an acute episode related to their acute illness episode and quite often a result of life saving interventions. These as the pt improves do resolve and heal
Guys and St Thomas NHS Foundation Trust	General	Guidance regards the use of the terms avoidable and unavoidable when reporting as there is a lot of subjectivity regards this across the healthcare sector resulting in anomalies in reporting which leads to inequality when benchmarking
Guys and St Thomas NHS Foundation Trust	General	Reporting – clearer guidance on prevalence versus incidence and a move towards aligning this to help with the streamlining of reporting across the healthcare sector and comparing like with like data
Cumbria Partnership Foundation Trust	General	- Great to have highlighted need for pressure ulcer management and assessment on neonates, infants and children, as well as labouring women. -I do feel this is very hospital based and with more complex, patients being discharged to community, this policy needs to cover both challenges. -It does accurately reflect key areas for quality improvement.. Children's guideline which previously didn't exist & we were adapting adult guidelines; guidance for transferring child to adult services; & guidance on preventing heel ulcers & raising the awareness of them
NHS England (Midlands & East)	General	Pressure Ulcer prevention should be included in standard professional training for all Healthcare Professionals. For Care staff this could be underpinned through the Professional Standards Authority requirements. Consideration could be given for Care and Residential Homes to accredit their homes based on completion of their training programme. This could be strengthened through both Clinical Commissioning Group and Local Authority contracts. The 'Stop the Pressure' website www.stopthepressure.co.uk hosts a range of resources including games; pressure ulcer pathway for assessment of pressure ulcers; 5 steps simple guide to pressure ulcer prevention (SSKIN) and articles to support training and development around pressure ulcer prevention. There is also a resource that provides an overview of responsibilities for pressure ulcer prevention for Patients and Carers through to the Executive Board members of a Trust.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		The Programme Board is working with partners who are developing and piloting resources for both Care and Residential Homes. Research is a second priority for this year. The website will be enhanced further to provide links to research around Pressure Ulcers. The 'Stop the Pressure' Programme Board are working in partnership with a stakeholder to explore engagement with the Professional Standards Authority around the requirements for registration of Care Home staff once they are trained in Pressure Ulcer prevention. The stakeholder is also developing an accreditation programme for Care Homes once they have undergone a training programme. The 'Stop the Pressure' Programme Board are working in partnership with Universities and supporting them to host Student Nurse conferences to raise the profile of Pressure Ulcer prevention amongst the student nurse population. Resources have been developed that are student specific by students which have been distributed across the Midlands & East Region and are now being distributed more widely through Health Education England. We are currently working with more Universities to host further Student Nurse conferences.
Kettering General Hospital NHS Foundation Trust	General	*First sentenc*e: should be amended to read "sufficient pressure or distortion to impair". This would ensure inclusion of the shear forces that are known to contribute to pressure ulcers
Kettering General Hospital NHS Foundation Trust	General	*2nd sentence*: add "already compromised skin" to the list of factors likely to increase risk of pressure ulcer (PU) *3rd sentence:* change "can cause pressure ulcers" to "can contribute to pressure ulcers". (not "cause pressure ulcers) in the interest of clarity and accuracy
Kettering General Hospital NHS Foundation Trust	General	*Last sentence on percentage avoidable.* Recent research in acute care by Downie et al (2013; 2014) identifies that the percentage avoidable can be as low as 34%. This figure should be reflected in the text rather than presenting a figure that suggests failures in care are almost always the cause of PU.
Alder Hey Children's NHS Foundation Trust	General	• My only observation from reading the document is that it primarily focuses on the nursing strategies to manage pressure sore risk but it doesn't really focus on how it plans to address nutritional concerns/screening? add in nutritional screening

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Department of Health	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
Royal College of Paediatrics and Child Health	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Pressure Ulcers draft standard. We have not received any responses for this consultation.
British Geriatrics Society	General	There is a need to have to read a lot of other 'read in conjunction with' documents which is not always easy for busy clinicians which often means the whole guidance goes unread. As often in these guidance, training being 'sufficient and appropriate' is key but this often falls to providers to ensure and maybe should be reflected in commissioning specifications as part of provider services targets? Nearly all of what is in this document is not new.
British Infection Association	General	The BIA believes that a quality standard, where appropriate, should contain quality statements that specifically address practices that should be avoided, especially if such practices are widespread and could lead to patient harm. In the context of pressure ulcers, the BIA is anxious to draw attention to the undesirability of collecting swabs for bacteriological analysis in such lesions. In particular, the collecting of swabs because of non-healing, odour, or slough is virtually always of no value and, even worse, can often mislead and thereby result in the administration of inappropriate antibiotics. The consequence is an overall increase in patient harm (e.g. through adverse drug reactions, *Clostridium difficile* infections) and public health harm (through increased antibiotic resistance) with no clinical benefit. The BIA would be happy to assist in the wording of a quality statement to address this important issue.
British Infection Association	General	The BIA would like to suggest that a quality statement which covers the necessity of excluding underlying osteomyelitis with appropriate investigations should also be considered. Again, we would be available to assist with the wording.
Society of Chiropodists and Podiatrists	General	When an inpatient acquires a new foot ulcer, it results – on average – 13 extra bed days per patient. If pressure relief (costing a maximum of £100/ inpatient) can prevented ulceration The Scottish Diabetic Foot Action Group introduced a national inpatient foot care campaign, called "CPR for Diabetic Feet". This involves a strategy of foot "checks", "protection", and "referral" (i.e. "CPR"). The

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		campaign sets out to ensure that all patients with diabetes who are admitted to hospital have their feet checked on admission, and if they are at risk of developing a foot ulcer, as assessed by insensate feet or fragile skin, their feet are protected, and if they have a current foot ulcer they are referred to an appropriate member of the foot care team. There has been a move via this campaign to try and simplify and standardise the appropriate pressure relieving devices that are being supplied to inpatients throughout Scottish Hospitals. There are a number of devices available and the most commonly used devices are listed in the Training Manual but with the recently introduced devices from TalarMade and the already widely used Pressure Relieving Ankle and Foot Orthosis (PRAFO) from Anatomical Concepts Ltd this may help to achieve this. CPR for Diabetic Feet was introduced throughout Scotland from April 2014 and a further audit will be undertaken following introduction to evaluate what impact the initiative has achieved. Three factors will help motivate people to ensure CPR for diabetic feet is introduced: 1. The drive to prevent harm to our patients. 2. The drive to improve the quality of patient care. 3. The drive to ensure resources are used more efficiently CPR for diabetic feet will help support all three motivations. While some clinicians will say “I can’t afford the time to carry this out”, the answer to them is “You can’t afford not to carry it out”. It only takes 30 seconds to check a patient with diabetes’ feet: spend 30 seconds, save 13 hospital bed days ... and possibly a lot more! A LearnPro module is accessible to hospital staff via local intranets to raise awareness surrounding the risk of hospital-acquired diabetic foot ulceration and its management.
Royal College of General Practitioners	General	“Pressure ulcers are caused when an area of skin and the tissues below are damaged …..” needs to be change to “Pressure ulcers are caused when an area of skin and***/***or the tissues below are damaged” . this addition can give space to include stage 1 pressure ulcer where the damage only include skin. “Typically they occur in a person confined to bed or a chair by an illness …….” needs to be change to “Typically they occur in a person confined most of the time to bed or a chair by an illness …”

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		(AA)
Royal College of General Practitioners	General	" Staffing levels can……." . This needs more clarification for what meant by staffing levels (AA)
Royal College of General Practitioners	General	It's a very good guideline with significant training and resource implications if all those admitted are to be assessed! It's also good practice for all those being nursed in the community to have this kind of assessment and to have appropriate help. We're rather taking adequate nutrition as read, but it is also a factor. (JA)
NHS England (Midlands & East)	General	The Clinical Commissioning Groups and Local Authorities could consider moving to joint contracts in relation to quality metrics for Care Homes. This would ensure consistency for Care Home residents, regardless of who funded their care. Across the Midlands & East the 'Stop the Pressure' Programme Board are developing a '10 steps simple guide' for Commissioners in relation to Pressure Ulcer prevention.
Kettering General Hospital NHS Foundation Trust	General	*ALL of these* should refer to "people identified as <u>at risk</u>" (delete the word "high") Interventions should be the proportionally taken for those at risk and at high risk, so specifying the latter provides an escape clause for those who fail to deliver these essential care components if they claim a patient "is only at risk not high risk"
Newcastle upon Tyne Hospitals NHS Foundation Trust	General	People identified at high risk….. remove "high" as patient are "at risk" or "not at risk"; using the term "high" risk leaves too much for individual interpretation.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Question 1	What is missing in your list of statements is one about "planning and delivering care". You have assessed the patient risk; you have looked at their skin (if at risk); you have told the patient that s/he needs to move, given information sheet and a mattress. What about a plan of care and has this been delivered?
Gloucestershire Hospitals NHS	Question 1	The Trust was in agreement that yes it did push pressure ulcer prevention management further. For Neonates there could be a recommendation on best 'assessment tool' for this patient group.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Foundation Trust		
Medway Community Healthcare	Question 1	Yes these should all be included in the standards.
NHS England (Midlands & East)	Question 1	Yes, this Quality standard does reflect the key areas for quality improvement. However, it could be enhanced further by including the requirement for an individualised care plan developed jointly with patients and / or their carers for those at high risk including those patients who have previously had a pressure ulcer who require secondary prevention. Consideration also needs to be given as to whether Residential Homes are included which would require engagement with Local Authorities. Although it is difficult to measure, Domiciliary Care providers should also be considered as this group provides care to significant numbers of patients at risk. The Midlands & East 'Stop the Pressure' Programme Board chaired by Ruth May, Regional Chief Nurse, have identified Care Homes as one of its priority areas for this coming year and as part of this are working with a group of Independent Care Home Chief Nurses to develop a programme of work to share best practice in Pressure Ulcer prevention. This has included their engagement with the November 2014 – 'World Stop the Pressure Day' alongside the sharing of resources available on the Stop the Pressure website within their Care Homes www.stopthepressure.co.uk The 'Stop the Pressure' Programme Board are working with projects that are in the early stages of developing support and training programmes for the Care Home sector across the Country.
Kettering General Hospital NHS Foundation Trust	Question 1	Question 1. Yes, the quality standard does reflect the key areas for quality improvement
British Geriatrics Society	Question 1	The standard focusses on the need to undertake assessment, but does not then reinforce the need to manage the risks with a care plan or care bundle package, which should then be reviewed. It does not reinforce the need to manage all the risks factors; focus is on the highest risk factors. It does not require all staff to undertake regular review of their competence, nor include the requirement that staff should understand the issue of moisture lesions. The areas of improvements are in the implementation and review of that care plan, not simply the assessment.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		Therefore this standard does not wholly reflect the key areas. It does not include any reference to caring for people who are unable to understand or who are non compliant with repositioning. There should be reference and guidance as to how staff make Best interest Decisions in these circumstances..
Tissue Viability Society	Question 1	The main concern clinically is that patients are assessed and care planned but not reassessed and changes in interventions when condition changes. This applies to acute care but particularly patients in community with long term conditions who receive minimal health care but their condition deteriorates either rapidly or slowly. It is not clear that these quality standards will fully capture these situations.
British Specialist Nutrition Association	Question 1	The draft Quality Standard acknowledges that pressure ulcers are more likely to occur in people who are seriously ill, have a neurological condition, impaired mobility, impaired nutrition, or poor posture or a deformity. Given that impaired nutrition is a risk factor for people considered to be at high risk of developing a pressure ulcer, the BSNA considers that the Quality Standard should include specific reference to nutritional screening, and the appropriate steps to take in the event that screening identifies a patient to be at risk of pressure ulcers due to nutritional factors. Nutritional screening and management of nutritional status is referred to in the NICE Clinical Guideline on Pressure Ulcers (NICE Clinical Guideline CG179). Specifically, Section 1.4 (pages 20-21) of the Clinical Guideline is dedicated to the management of pressure ulcers for adults and includes a number of recommendations with regard to nutritional screening and assessment and the use of nutritional supplements and hydration: 1.4.4 Offer adults with a pressure ulcer a nutritional assessment by a dietitian or other healthcare professional with the necessary skills and competencies. 1.4.5 Offer nutritional supplements to adults with a pressure ulcer who have a nutritional deficiency. 1.4.6 Provide information and advice to adults with a pressure ulcer and, where appropriate, their family or carers, on how to follow a balanced diet to maintain an adequate nutritional status, taking into account energy, protein and micronutrient requirements. 1.4.7 Do not offer nutritional supplements to treat a pressure ulcer in adults whose nutritional intake is adequate.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		1.4.8 Do not offer subcutaneous or intravenous fluids to treat a pressure ulcer in adults whose hydration status is adequate Similarly, Section 1.5 of NICE Clinical Guideline 179 provides guidance on the management of pressure ulcers in neonates, infants, children and young people (see 1.5.4 - 1.5.9, pages 24-25) and also refers to nutritional screening and assessment and the use of nutritional supplements and hydration for these age groups. The BSNA considers that the draft Quality Standard should include specific reference to nutritional screening, and the appropriate steps to take in the event that screening identifies a patient to be at risk of pressure ulcers due to nutritional factors. The link to NICE Clinical Guideline 179 in the draft Quality Standard appears to be incorrect. The correct link is: http://www.nice.org.uk/guidance/cg179/resources/guidance-pressure-ulcers-prevention-and-management-of-pressure-ulcers-pdf
Royal College of General Practitioners	Question 1	Question 1: Answer 1: yes Question 2 Answer 2: yes if enough manpower added to systems and structures Question 3: Answer 3: - Enough education to patients and carers - Frequent audit to different health care services - Promotion to successful health care services to achieve and hold improvement Question4: using the same risk assessment tool used initially can help in reassessment if clinical status changed (AA)
College of Occupational	Question 1	There are a number of areas where it would be good to do further work around the prevention and management of pressure ulcers, however this statement does seem to reflect those of highest priority.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Therapists		The College is particularly pleased to see pressure relieving devices and repositioning included as these are two areas where occupational therapists would have significant involvement but where there is also significant variation in practice.
British Association of Dermatologists	Question 2	Yes it should be possible to collect the data proposed.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Question 2	yes data can be collected.
Kettering General Hospital NHS Foundation Trust	Question 2	Question 2. Yes, it would be possible to collect the data for the proposed quality measures if the systems were available
Gloucestershire Hospitals NHS Foundation Trust	Question 2	• Again yes. We felt that organisations with Clinical Systems could achieve this, however, those without would need a paper based audit exercise. The burden of this would depend on any stated sample size etc. We felt further questions could be added to the Safety Thermometer questions, if this 'snapshot' approach was acceptable
Medway Community Healthcare	Question 2	I'm sure that within in-patient units this would be possible. I am not sure how the standard could be measured in the community in an accurate manner as there is a huge variety of staff seeing the patients and recording is not standard – some on CHS and some on paper etc. A similar question has been raised at the Kent wide pressure group where in-patients use number of bed days to establish prevalence – this is not possible in the community.
NHS England (Midlands & East)	Question 2	Yes, if the systems and structures were available it would be possible to collect the data for the proposed quality measures. However, what would be key to this would be the requirement for a collaborative approach across the whole patient pathway, led primarily by Clinical Commissioning Groups and Local Authorities. Underpinning this work could be a standard requirement for a Root Cause Analysis if a Pressure Ulcer did develop so that the root cause could be determined within the quality measures in place. An Expert Working Group of Tissue Viability Nurses from across the Midlands & East Region supports the 'Stop the Pressure' Programme Board in its delivery of its programme of work. Amongst its priorities for this year is to determine the minimum requirements for a Root Cause Analysis tool that it can be shared as best practice across the Region. This will include those elements of the Quality Standard

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		requirements.
British Geriatrics Society	Question 2	It will be difficult to collect such data in care homes without increased funding from commissioners and for those who pay privately for their care; effectively they will be paying for the increased administration of their own pressure management. There are also many people cared for in residential care who will be excluded from this as some aspects don't apply to social care workers. There is no clarity about the right of care home residents to have access to NHS resources in the community as part of the CCG commissioned service from local community provider. The wording of this standard is ambiguous and will lead to the usual postcode lottery of who gets NHS resources (Tissue Viability Nurse assessment and clinical support, equipment etc) and where care homes have to pay for it. Care homes get their money from 3 separate funding streams, The Local Authority, the NHS or the person themselves.
Tissue Viability Society	Question 2	For most of the standards as written, the systems and structures are very vague and will be open to local interpretation. This will result in lack of comparability between organisations and repeated audits in the same organisation.
College of Occupational Therapists	Question 2	Many of the measures talk about 'evidence of local measures' and we feel some of these could be more specific to make them more measureable: • This could be linked with regulation to give organisations a real motivation for ensuring that they have local measures - although it is always preferable to give a carrot rather than a stick to improve practice. • Organisations could be encouraged to take a quality improvement approach, perhaps sampling care plans of a certain proportion of patients per month and then embedding this into their routine measures band run charts, perhaps on a monthly basis and monitoring the impact of any practice changes on their data. However, organisations would appear to be at very different stages with this kind of approach. Multidisciplinary input is vital to holistic pressure care – but could make some of the standards more difficult to measure e.g. some information regarding devices or repositioning assessment may be in therapy notes.
British Association of Dermatologists	Question 3	Easy availability of standardised risk assessment forms would help and in particular for statement 4 provision/access to standardised recommended information for patients/carers would be beneficial.
Kettering General	Question 3	Question 3. Actions to support improvement and overcome barriers (not exhaustive)

Stakeholder	Comment on	Comments Please insert each new comment in a new row.

Hospital NHS Foundation Trust		• Targeted and focused education on identified components of care that need improvement within organisations to be followed by embedding what has been taught into practice
		• Audit to ensure best practice is delivered. Various options exist including
		  ○ Nurse sensitive indicators targeted at establishing compliance with best practice and implementation of learning (see above)
		  ○ Re-test following education to ensure knowledge is not lost
		  ○ Ongoing incidence – reduction in avoidable PUs is a surrogate indicator
		  ○ Safety thermometer – not a robust measure but currently the only one that is openly shared
		  ○ Monitor (and address any shortfalls in) PU prevention equipment use including any delays in obtaining and/or starting to use for patient care
		• Organisations to maintain focus on PUs as a key quality indicator, if necessary changing organisational culture to make it a priority which is driven at executive level and evidenced by
		  ○ Inclusion of PU reduction in provider contracts, monitored by all commissioners (NHS, Council, CQC etc.)
		  ○ Ward/department/private sector provider to demonstrate ownership of pressure ulcer prevention and exercise of accountability when avoidable PUs occur.
		  ○ Clear statements as to standard of care that must be delivered within that organisation including defined expectations and responsibilities of all professions/staff groups
		  ○ Feedback rates of PUs at all levels identifying reductions (positive reinforcement) and increases (negative reinforcement). May include displaying time since last avoidable PU within the care environment
		Include patient representatives and groups (e.g. Healthwatch) in practice improvement. Ensure that patients/carers are informed of PU risk so they can take some responsibility for themselves (if able) or have an expectation of what care they should receive (if unable) and encouraging challenges if that isn't delivered

Gloucestershire Hospitals NHS Foundation Trust	Question 3	• The Trust felt that perhaps NICE could recommend the number of Tissue Viability nurses per head of patient to help education and embedding of the standards.
Medway Community Healthcare	Question 3	Mandatory training of all staff in the prevention and recording of pressure damage. Easy to complete systems for recording and retrieving the information required.
British Geriatrics Society	Question 3	Need to ensure good quality training and appropriate staffing levels

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Tissue Viability Society	Question 3	Most NHS Trusts have standards which are more comprehensive than these, which they currently audit against. The value will mainly be for those hard to reach organisations such as GP practices. Support for improvement should come through their governance arrangements.
British Association of Dermatologists	Question 4	Repeated risk assessment using a validated tool would be best.
Newcastle upon Tyne Hospitals NHS Foundation Trust	Question 4	what about linking it to NEWS (National Early Warning System) – that is a national tool to identify if a patient's condition is changing.
Gloucestershire Hospitals NHS Foundation Trust	Question 4	The Trust felt again this would be a combination of the design of the Assessment tool, where staff indicate that the reassessment is done due to a change in patient condition. Again we assess at least daily. Maybe this could be the starting point rather than "when condition changes" which could be open to misinterpretation.
Medway Community Healthcare	Question 4	I would have thought re-assessment using the same tool as before and noting/graphing any changes would do this.
NHS England (Midlands & East)	Question 4	How at an individual patient level could a repeat risk assessment following a change in clinical status be measured? There are numerous tools used within Acute and Community services that capture triggers for repeating a risk assessment and the documentation for this. This could be standardised with minimum requirements. On the 'Stop the Pressure' website www.stopthepressure.com.uk there are resources available which have been developed to support risk assessments.
Kettering General Hospital NHS Foundation Trust	Question 4	Measuring risk assessment following change in clinical status 1. Each provider must have a policy or protocol that includes a definition of 'change in clinical status' and actions to be taken, including repeated PU risk assessment 2. That policy must include a minimum interval at which status is to be reviewed so that gradual changes are not overlooked 3. The policy must include the organisation's approved PU risk assessment tool (if one is in use) and how it is applied in planning/delivering care At individual patient level this would enable

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		• Recording every repeated PU risk assessment, why it has been done (e.g. condition improved, deteriorated or designated interval to check for changes) its outcome and any changes from the previous assessment. The score should reflect an acute clinical change (if done for that reason) and slow or no changes if done at a predetermined 'check status interval' • Frequency of risk assessment can then be compared with that patient's other records to ensure none have been missed Compliance with policy can subsequently be audited and reported to commissioners (NHS, Council, CQC etc.)
British Geriatrics Society	Question 4	Measurement needs to be electronic. Maybe something like NEWS , which is quick to complete and with a score that reflects small changes that would highlight deterioration of pressure areas.
Tissue Viability Society	Question 4	A change in clinical status can be identified through a review of additional documentation e.g. observation charts (temp, pulse, etc), a change in mobility/activity care plan, a change in medication e.g. antibiotics. There should be evidence of a repeated risk assessment should any of these be identified.
Royal College of Nursing	Statement 1	The use of a risk assessment tool on admission or change in clinical status could be expanded to incorporate interventional tests or procedures. The definition does incorporate "after surgery" but this may need to be broadened as there are non-surgical tests and procedures that may increase a patient's risk of developing pressure ulcers as they restrict movement or mobility – for example radiological procedures. We also wonder if the risk assessment should also incorporate change of location. There may be an increased risk when moving patients between wards, hospitals and home or other location.
Kettering General Hospital NHS Foundation Trust	Statement 1	*Last sentence:* please change to "those people at risk helping to…" (delete the word "most") If not, this implies that those who aren't specifically high risk don't need prevention care
Sheffield Teaching Hospital NHS Foundation Trust	Statement 1	How to define 'a change in clinical status' – this could prove to be problematic as a patient's status could change very frequently and could lead to excessive reassessment and therefore workload. It would be helpful to have a more clearly defined statement on this point.
Sheffield Teaching Hospital NHS Foundation Trust	Statement 1	It will need a body chart for skin assessment and subsequent reassessment ideally in one document like a booklet and this could help address the monitoring/measuring for compliance of reassessment.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Sheffield Teaching Hospital NHS Foundation Trust	Statement 1	• The use of a risk assessment tool on admission or change in clinical status could be expanded to incorporate interventional tests or procedures. The definitions does incorporate "after surgery" but this may need to be broadened as there are non-surgical tests and procedures that may increase a patients risks of developing pressure ulcers as they restrict movement or mobility – for example radiological procedures. I also wonder if it should also incorporate change of location? There may be an increased risk when moving patients between wards, hospitals and home or other location. Quality measures from TVT and/ or STH 1. Evidence of arrangements to ensure healthcare professionals know how to use risk assessment tools to assess the risk of pressure ulcers. a. We should have some of this covered in terms of training and also Megan's poster b. May be a need to audit/ have checks to support that Waterlow is being calculated properly? 2. Evidence of arrangements to ensure that people admitted have a pressure ulcer risk assessment on admission. a. Potential need for audits and assessments of wards. b. They suggest assess compliance via reporting of number of Waterlows/ number of patients 3. Evidence of local arrangements to ensure that people admitted to hospital have a pressure ulcer risk assessment repeated if there is a change in clinical status. a. This was an area that I thought there were likely to be a number of difficulties in terms of collecting the data and defining. I also think that it is to narrow as there may need to be assessment when a patient is transferred or has a non-surgical intervention (such as a radiological procedure or epidural etc) that may restrict their movement. i. Collecting this data would be very problematic as would need to create/ provide clear criteria of change in clinical condition. There are also practical and training implications. For example: surgery – should this be done pre and post-op? If so, where and who does it? What about frequency?
Tissue Viability Society	Statement 1	This statement does not give a timescale, it is hard to audit without a time frame e.g. within 6 hours of admission to acute care and within 24 hours of admission to care home. The admission to a care home

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		does not state 'where NHS care is provided'.
Royal College of General Practitioners	Statement 1	Statement 1 needs to change to "people admitted to hospital or a care home have a pressure ulcer risk assessment on admission that is repeated following a change in clinical or mobility status".
College of Occupational Therapists	Statement 1	• See above concerns re: 'local measures' - risk assessment is likely to be initially recorded on a care plan but re-assessment may be recorded as free-text within notes and difficult to measure. • The criteria for the presence of a pressure ulcer on admission is often a grey area. Some trusts have a policy where if a pressure ulcer appears with a certain time of admission it is classed as a community acquired PU (and vice versa where patients are discharged back to community or to nursing homes). There should be agreement on this.
Alder Hey Children's NHS Foundation Trust	Statement 2	Comment on skin assessment. There is no mention about the risk of medical devices I.e. Cannula, Endotracheal tubes, drains etc. which have the potential to lead to device related pressure sores. Should this be incorporated into the assessment?
British Association of Dermatologists	Statement 2	The 5 quality statements included are generally good but for statement 2, we feel that frequent repeated skin assessment should be undertaken irrespective of change in clinical situation.
Royal College of Nursing	Statement 2	The earlier comments regarding risk assessment will also apply for skin assessment. This would be particularly important with patient transfers within and between institutions and locations. The quality statement as it currently stands does not mention the necessity to do this which we feel is an omission.
Royal College of Nursing	Statement 2	Within the equality and diversity implications there should also be a mention of issues related to skin assessment of those with darker skin. There can be difficulties identifying skin damage in these groups which may mean that initial and early pressure damage may not be picked up. There are potential training and equality issues linked to this.
NHS England (Midlands & East)	Statement 2	Skin assessment in adults should take into account: - any pain or discomfort reported by the patient. This should be regardless of whether there is evidence of any pressure ulcer development at that point. This would be a trigger for close monitoring.
NHS England	Statement 2	A skin assessment may not always be appropriate / possible in all care settings. The patient should

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
(Midlands & East)		however, be offered a physical skin assessment if appropriate and this should be documented. Alternatively, the patient/ carer could be asked about the skin status and whether they had any concerns. This would be an opportunity to highlight risks and what to look for including giving an information leaflet. Opportunities to highlight risks could be at points of contact with healthcare professionals such as GP surgery or other Outpatient setting including Therapy sessions. The 'Stop the Pressure' Programme Board are working with a partner who has developed an information leaflet which is currently being piloted within GP practices and at Healthcare points of contact with Patients and their Carers.
Kettering General Hospital NHS Foundation Trust	Statement 2	*Sentence 2.* Change to "skin assessment should be performed… and may indicate the potential development of a PU" (replace the word 'predict'). The use of 'predict' suggests that further deterioration is inevitable but prevention at an early stage often leads to resolution without serious injury.
Kettering General Hospital NHS Foundation Trust	Statement 2	Change the words "at high risk" to "at risk". Changing this identifies that all patients at risk of PUs should receive appropriate prevention care
Kettering General Hospital NHS Foundation Trust	Statement 2	Change the words "at high risk" to "at risk". Changing this identifies that all patients at risk of PUs should receive appropriate prevention care
Kettering General Hospital NHS Foundation Trust	Statement 2	*Page 13 line 3.* Reword to "skin integrity in areas subject to pressure and shear including from any medical devices" Current fragment has no meaning and fails to focus attention on potential device-related PUs
Oxford Health NHS Foundation Trust	Statement 2	In the patient's own home, where staff are seeing a patient for various other primary reasons (for instance to administer medications), it may not be appropriate to undress the patient purely to do a full skin assessment. In these circumstances, a skin assessment can be offered, and/or talk to the patient and carer about their skin condition and enquire whether they have any sore skin, any dry skin, problems etc. If carers are involved in providing personal care to the patient, they can be asked to monitor the skin and report any problems. Could this standard have a caveat re. patients in their own home, to say that they are offered a skin assessment, and if not appropriate, skin condition is discussed with patients and carers.
Sheffield Teaching Hospital NHS	Statement 2	"People identified at high risk of developing a pressure ulcer in any setting have a skin assessment." Comments about QS

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Foundation Trust		• The comments regarding risk assessment will also apply for skin assessment. This would be particularly important with patient transfers within and between institutions and locations. The current quality statement does not mention the necessity to do this which I feel is an omission. • Within the equality and diversity implications there should also be a mention of issues related to skin assessment of those with darker skin. There can be difficulties identifying skin damage in these groups which may mean that initial and early pressure damage may not be picked up. There are potential training and equality issues linked to this. Quality measures from TVT and/ or STH 1. Evidence of local arrangements to ensure that people identified at high risk of developing a pressure ulcer in any setting have a skin assessment. a. This implies that only those with a Waterlow of 15 or more should have a skin assessment. b. There are issues of documentation, structure, format, assessment of darker skin, resource and training. c. There should be some link to QS3 for repositioning in that moving a patient should be linked to assessing the status of their skin in order to evaluate if need more frequent turns. d. Suggest that measure this by: proportion of people newly identified at high risk of developing a pressure ulcer who have a skin assessment. Not sure that we collect these data as an organisation.
Tissue Viability Society	Statement 2	This statement should say ‘people identified at risk’ not just high risk should have a skin assessment. Skin status is a risk factor for pressure ulcers, without looking at the skin then risk cannot accurately be assessed for any patient.
Royal College of General Practitioners	Statement 2	Statement 2 needs to change to “people identified at high risk of developing a pressure ulcer in any setting have periodically skin assessment” (AA)
College of Occupational	Statement 2	See above concerns re: ‘local measures’ - risk assessment is likely to be initially recorded on a care plan but re-assessment may be recorded as free-text within notes and difficult to measure.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Therapists		
Royal College of Nursing	Statement 3	Consider explicitly linking this quality statement to Quality Statement 2. Skin assessment should be undertaken at times of repositioning to evaluate whether there is a need for more frequent repositioning.
NHS England (Midlands & East)	Statement 3	Repositioning and those patients unable to do so are offered help- Not all patients have ongoing District Nursing care or carers to provide support for repositioning. Domiciliary Care Providers are a group of care providers who support some patient groups and as such would need including in relation to training programme and requirements. Changing position frequently – this is quite broad and would be strengthened by having timescales such as minimum 4 – 6 hourly.
Kettering General Hospital NHS Foundation Trust	Statement 3	*b) & c)* Only a single data stream is necessary to include "proportion of adults identified as at risk of developing a pressure ulcer and needing help to change their position that have a record of repositioning which is appropriate to their clinical need and level of pressure ulcer risk". The inclusion of stated 4 hour interval for at risk patients and 6 hours for high risk is unsafe – repositioning interval must be assessed and agreed with each patient rather than following edict by risk level (which is often badly completed anyway with risk assessment tools over-predicting even if completed properly). It also allows an opportunity for a 'get out clause' for providers who fail to identify patients who need more repositioning than that stated and are, consequently, neglectful towards their patients but could use NICE to justify that behaviour. *d)* As adult for same reasons
Sheffield Teaching Hospital NHS Foundation Trust	Statement 3	"People identified at risk of developing a pressure ulcer in any setting are advised to change their position frequently and offered help to do so if needed." Comments about QS • Consider explicitly linking this quality statement to QS2. Skin assessment should be undertaken at times of repositioning to evaluate whether there is a need for more frequent repositioning. Quality measures from TVT and/ or STH 1. Evidence of local arrangements to ensure that people identified at risk of developing a pressure ulcer in any setting are advised to change their position regularly a. Does not specify how this advice is given.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		b. Can see difficulties with finding out and recording the number who are advised to change position frequently and dividing this by the number of people identified at risk of developing a pressure ulcer – all patients might be at risk it's a question of level of risk. 2. Evidence of arrangements to ensure that people who are unable to reposition themselves, are offered help to do so. a. NICE suggest that data is collected on the proportion of adults identified at risk of developing a pressure ulcer and needing help to change their position and the record of repositioning every 4-6 hours. There are potential issues of: i. Data collection ii. Providing mixed messages regarding 2 hourly turns iii. Effectiveness of repositioning and linkage with skin assessment and pressure relieving devices.
Tissue Viability Society	Statement 3	This has three elements: a) advice to change to position, b) identification of those who are unable to change their own position c) the offer of help to those unable all these should be documented in the clinical records
Royal College of General Practitioners	Statement 3	Structure a) Evidence of local ……to change their position **frequently.** The word frequently should be defined to be measured Process a) Proportion of people …… to change position **frequently** The word frequently should be defined to be measured (AA)
College of Occupational Therapists	Statement 3	• This is complex to measure as ideally it should include multidisciplinary assessment and re-assessment therefore evidence may be included in therapy notes. • See above concerns re 'local measures' – risk assessment likely to be initially recorded on a care plan but re-assessment may be recorded as free-text within notes and difficult to measure. • Written documentation needs to be very specific regarding the frequency of repositioning and the equipment required. • Some people may not be able to reposition themselves but can be positioned to enable them to engage in an occupation (activity) that they either wish or need to do. A plan to ensure that they

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		are repositioned regularly but that also enables them to engage in ongoing activity is important. Therefore, the description of repositioning should also include a wheelchair, as well as chair or bed to reinforce that a person may still be active even when they need assistance to move. Carers often recognise the need for pressure relieving cushions/mattress for an individual but do not necessarily request an assessment for a wheelchair to be appropriately adapted. Care homes and other residential settings often use communal wheelchairs. • Some occupations may be important to a person to be able to do but put them at greater risk of a pressure ulcer due to the position they adopt in order to engage in the activity or the length of time they spend in one position. A full assessment is then required to advise on alternative positioning, equipment or scheduling breaks. • There needs to be a clear method of recording when repositioning has been offered but declined by the patient. This statement has significant implications for social care in terms of the frequency of packages of care.
Sheffield Teaching Hospital NHS Foundation Trust	Statement 4	This guidance doesn't address the management of those patients unable to understand the advice/ information about pressure sore prevention. Some of the most vulnerable and 'at risk' people are those who are fit into this particular category with neurological and cognitive impairment.
Sheffield Teaching Hospital NHS Foundation Trust	Statement 4	Development of Patient information should include the non-compliant issues – i.e. if you do not change position, refuse to eat and drink, have hygiene attended to then this will compromise your skin and pressure areas further. Could also include a section for intensive care patients and the effect of inotropic drugs on the circulation/skin. Also a section on equipment and use of mattress/boots/cushion and where to access these when going home.
Royal College of Nursing	Statement 4	The methods for the provision of information are not specified. Does the information need to be verbal or written? If verbal then there are likely to be issues in terms of capturing these data.
Royal College of Nursing	Statement 4	The draft Quality Statements did not mention the information needs for those who have developed a pressure ulcer.
Royal College of Nursing	Statement 4	There are also potential issues of how to ensure understanding, frequency of information provision and severity of pressure damage – different information will be needed depending on whether the patient is at risk, pressure damage has occurred and depth of damage.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
NHS England (Midlands & East)	Statement 4	Where reference is made to giving information to people and their carers identified at high risk of developing a pressure ulcer (including those patients who have previously had a pressure ulcer and are at risk) this would be strengthened by including both verbal and written information. Consideration should also be given as to whether information about prevention should be given to those patients who are at risk but not necessarily high risk. The 'Stop the Pressure' Programme Board are working with the National Patient Safety Team who are developing a patient information leaflet. This will then be shared on the website as a resource for carers and patients. They are also looking at the wider Public Health agenda and how this fits in with a Patient and Carer campaign.
Kettering General Hospital NHS Foundation Trust	Statement 4	*Para 1, sentence 1.* Please change to "A significant proportion of pressure ulcers are preventable". Use of the word 'many' suggests use of old research that is no longer substantiated in secondary care with pending publications likely to identify the same in primary care. Changing to 'significant' will cover both old and new evidence-bases so this QS won't be called into question on the point
Kettering General Hospital NHS Foundation Trust	Statement 4	This statement continually and solely refers to pats at high risk of pressure ulcers. However, it is essential that patients with any risk of pressure ulcers (and/or their carers) are provided with the information they need to help themselves avoid injury. Please change the content to reflect this
Sheffield Teaching Hospital NHS Foundation Trust	Statement 4	"People identified at high risk of developing a pressure ulcer in any setting, and their carers, are given information on how to prevent them." Comments about QS • The methods for the provision of information are not specified. Does the information need to be verbal or written? If verbal then there are likely to be issues in terms of capturing these data. • The QS does not mention the information needs for those who have developed a pressure ulcer. • There are also potential issues of how to ensure understanding, frequency of information provision and severity of pressure damage – different information will be needed depending on whether the patient is at risk, pressure damage has occurred and depth of damage. Quality measures from TVT and/ or STH 1. Does not specify how this information is given whether verbal or written. It also does not specify what if any information is given to those with low/ medium risk and existing pressure ulcers. a. Need to distribute information sheets more widely as a TVT and also record that we have done this as need to provide info on the proportion of those at high risk that are given info.

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Tissue Viability Society	Statement 4	This needs changing to all 'people at risk' not just those at high risk, should be given information. This can be challenging to audit. Often it is not appropriate to give information e.g. to those who lack capacity, risk may have been discussed with patients but information not retained or leaflets given (as part of a bundle of information) and the patient has discarded them. The denominator should take into account those patients who it would be inappropriate to give information. Considerations for the numerator included: do you ask the patients and carers, do you expect it to be documented in clinical records in every case.
College of Occupational Therapists	Statement 4	• See above concerns re: 'local measures' - may be recorded as free-text within notes and difficult to measure. • May need local arrangements to monitor the quality and accuracy of such information. May need local arrangements to define if information should be written, verbal or both.
Royal College of Nursing	Statement 5	Should consideration be given to what would be a reasonable duration for patients to wait/ have access to redistribution equipment? What are and are there any reasonable waiting times to be placed on a pressure relieving mattress?
NHS England (Midlands & East)	Statement 5	Consideration needs to be given to those patients at high risk but who are not on the District Nursing caseload for any other nursing needs. These patients would not necessarily have equipment provided. There is no current service for equipment provision and assessments of patient's suitability for such. For example, the patient may be seen by the Practice Nurse and be identified as being at high risk but the Practice Nurse / GP would not necessarily refer the patient to the District Nurse, nor would they assess / provide the patient with equipment. The patient would not fit the criteria for District Nurse caseload admission based solely on being at high risk. The Expert Working Group supporting the 'Stop the Pressure' Programme Board has one of its priorities around Equipment and use and appropriateness of equipment. This work will be in partnership with Leeds University.
NHS England (Midlands & East)	Statement 5	Evidence of local arrangements to provide pressure redistribution devices for people with an existing pressure ulcer or those identified at high risk of developing. This could be strengthened by including those patients who have previously had a pressure ulcer and require support through secondary prevention.
NHS England	Statement 5	Waiting times to receive pressure redistribution devices – this could be strengthened by including time

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
(Midlands & East)		from the point at which there was an identified need for a device AND from the point of a device being requested. There can be a variation in these times.
NHS England (Midlands & East)	Statement 5	Could add to this section that appropriate pressure redistribution devices are given appropriate to the level of risk that the patient has been assessed at. The Midlands & East 'Stop the Pressure' Programme Board have identified Care Homes as one of its priorities for the coming year and have identified that there is a need to focus on the wider patient pathway within the preventative agenda. This work is being taken forward in partnership with key stakeholders who are members of the Board.
Kettering General Hospital NHS Foundation Trust	Statement 5	*Statement 5 only (additional):* please change to "access to pressure redistributing or relieving devices" to include the wider range of devices available
Kettering General Hospital NHS Foundation Trust	Statement 5	Please change to "access to pressure redistributing or relieving devices" to include the wider range of devices available
Kettering General Hospital NHS Foundation Trust	Statement 5	Please change "high risk" to "at risk". Equipment may be needed by patients whose formal risk score isn't in the 'high' range (see above re: inaccuracy of these)
Kettering General Hospital NHS Foundation Trust	Statement 5	The QS fails to identify measures to elevate or 'float' heels to prevent pressure ulcers to that area as well as the increasing rates of medical (or other) device-related injuries. Equipment should not, therefore, be limited to support surfaces and should and include heel protection as well as options for preventing pressure from O_2 delivery systems, plaster casts, orthoses and joint support or immobilisation devices
British Association of Prosthetists and Orthotists (BAPO)	Statement 5	In this section there is no reference to orthoses. During the initial engagement exercise BAPO highlighted the importance of orthoses in prevention of pressure ulcers in the described patient population. Omitting reference to orthoses in this guideline may result in provision of orthoses being overlooked and thus deprive patients of a valuable treatment option. BAPO does not feel it can endorse this guideline without reference to the role of orthoses. Orthoses may act as pressure redistribution devices. BAPO believes prescription of orthoses to be common practice, often being used to protect the heel from pressure ulcers. This has been discussed in

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		literature: (http://journals.lww.com/orthopaedicnursing/Abstract/2000/19050/Preventing_Heel_Breakdown.11.aspx). One study generated inconclusive results when comparing heel protection devices to cushions. (http://journals.lww.com/jwocnonline/Abstract/2009/11000/Are_Pressure_Redistribution_Surfaces_or_Heel.6.aspx) This highlighted that heel protection devices may have advantages over cushions/pillows and these include protection during ambulation, prevention of muscle contracture and the ability to wick moisture. Unlike a cushion/pillow, the orthosis is attached to the patient pressure relief will be maintained if the patient moved position. Similar advantages of orthoses were stated in a nursing journal article: (http://journals.lww.com/nursing/Citation/2004/11000/Preventing_heel_pressure_ulcers.12.aspx) The PRAFO (Pressure relieving ankle foot orthosis) is one example of an orthosis acting as a heel protection device. The following case studies demonstrate use and clinical outcomes: (http://issuu.com/anatomicalconcepts/docs/prafo_poster/1) BAPO acknowledges that are several orthoses available that can redistribute pressure away from the heel. Each ha distinct characteristics that help to ensure that provision is patient specific. As such, BAPO would stress that the orthotist is the most appropriately trained and experienced profession to assess for, prescribe, fit and review orthoses acting as heel protection devices.
Sheffield Teaching Hospital NHS Foundation Trust	Statement 5	"People with an existing pressure ulcer or identified at high risk of developing one, in any setting, have access to pressure redistribution devices." Comments about QS • Should consideration be given to what would be a reasonable duration for patients to wait/ have access to redistribution equipment? What are and are there any reasonable waiting times to be placed on a pressure relieving mattress? Quality measures from TVT and/ or STH 1. Evidence of local arrangements to provide pressure redistribution devices for people with an existing pressure ulcer or identified at high risk of developing one. a. This to be measured by the proportion of people with an existing pressure ulcer or identified at high risk of developing one needing a pressure redistribution device who

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		receive it and also from feedback from people with an existing pressure ulcer or identified at high risk of developing one and from their family or carers that they are satisfied with the care they have been given. i. Does not specify the timescale or waiting time or type of equipment and also does not detail evaluations of the effectiveness of using this equipment. ii. Some of the info could be from sources such as the Friends and Family or inpatient survey.
Tissue Viability Society	Statement 5	All patients identified at risk should have access to devices, not just those at high risk. The process numerator should include all those who are offered a range of devices but refuse. Guideline says all patients admitted to secondary care - this can be audited. There should be some standards about time to receiving equipment otherwise it is hard to audit.
College of Occupational Therapists	Statement 5	• Complex to measure as ideally it should include multidisciplinary assessment and re-assessment therefore evidence may be included in therapy notes. • There needs to be a means of evidencing the appropriateness and timeliness of the assessment. • There needs to be a means of evidencing the timely availability of the recommended equipment. • There needs to be a means of evidencing the ongoing review of both the equipment and of the patient's needs. We welcome the inclusion of seating in this statement.
Royal College of Nursing	Briefing paper	The Statement "pressure ulcers are usually categorised into 4 categories based on the European Pressure Ulcer Scale: None: No pressure ulcer, or a pressure ulcer that is deemed less severe than a Category 2." The above statement is incorrect as 'None' means 'none' i.e. there is no pressure damage. There is however a Category 1 which means redness of the skin which does not blanche
Royal College of Nursing	Briefing paper	"Pressure ulcers can result in severe harm or death and research suggests that between 80-95% are avoidable" – More recent data suggests that this statement is not accurate please see: Downie F, Guy H, Gilroy P, Davies S (2013). Are 95% of hospital- acquired pressure ulcers avoidable? ➢ Wounds UK9(3); 16–22 ➢ Downie F, Sandoz H, Gilroy P et al (2014). Avoidable pressure ulcer rates in six acute UK

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		Trusts? Wounds UK 10(3); 48–52 There are currently no nationally collected data on pressure ulcer incidence and prevalence apart from the Safety Thermometer Data.
Royal College of Nursing	Briefing paper	"Categorisation NICE CG179 Recommendation 1.4.3 (adults) Categorise each pressure ulcer in adults using a validated classification tool (such as the International NPUAP-EPUAP [2009] Pressure Ulcer Classification System). Use this to guide ongoing preventative strategies and management. Repeat and document each time the ulcer is assessed. NICE CG179 Recommendation 1.5.3 (neonates, infants, children and young people) Categorise each pressure ulcer in neonates, infants, children and young people at onset using a validated classification tool (such as the International NPUAP-EPUAP [2009]) Pressure Ulcer Classification System) to guide ongoing preventative and management options. Repeat and document each time the ulcer is assessed." There is a wealth of information suggesting that even experts cannot reliably categorise pressure ulcers – there is no clinical benefit to assigning a category to the damage – it is therefore a huge waste of time. Many Tissue Viability Nurses waste hours of valuable time teaching how to categorise and then 'validating' the category of damage when it is reported – with on average 20% of reports being inaccurate. If it makes no difference to the care delivered why are we doing this?
Cumbria Partnership Foundation Trust	Briefing paper	Do we not need to include shear in our definition here as it is included in EPUAP which we are referencing?
Cumbria Partnership Foundation Trust	Briefing paper	If we are following EPUAP, what about Grade 1 pressure damage? Should we also be including ungradeable and deep tissue injury? The definitions described in the document, are not word for word EPUAP which may cause confusion?
Cumbria Partnership Foundation Trust	Briefing paper	Unable to access this reference. Rather than a generic poster, should it not be an academic article?
Cumbria Partnership Foundation Trust	Briefing paper	''Physical therapy' – what does this mean?
Cumbria Partnership Foundation Trust	Briefing paper	Table 3, Information and Training Row: Do the staff training numbers apply to community as well as hospital based?
Cumbria Partnership	Briefing paper	'Risk': A national risk assessment scoring tool would standardise this aspect of management and would

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
Foundation Trust		allow easier movement between services and Trusts. Training could also be standardised improving accurate usage.
Cumbria Partnership Foundation Trust	Briefing paper	'Maintaining healthy skin': Could we refer to Best Practice Statement for care of the older persons skin here?
Cumbria Partnership Foundation Trust	Briefing paper	'Repositioning' '24 hour centred approach': Is this achievable in the community?
Cumbria Partnership Foundation Trust	Briefing paper	'Risk assessment' 'Mobility' Is this appropriate for community? We currently reassess 3 monthly, or sooner if condition changes.
Cumbria Partnership Foundation Trust	Briefing paper	'Risk assessment' Good to see infants and neonates are included in this policy.
Cumbria Partnership Foundation Trust	Briefing paper	'Skin Assessment' 'assessed as being at risk' Should this stay at 'high risk' or should it go to 'at risk'? We currently assess skin (visually) in patients 'at risk' and above.
Cumbria Partnership Foundation Trust	Briefing paper	'Repositioning' '6 hours': Possibly OK at night lying flat but in a chair is 6 hours too long without repositioning? We are wanting to encourage our patients to keep moving.
Cumbria Partnership Foundation Trust	Briefing paper	'Repositioning' '4 hours': Good to see at least 4 hourly in high risk patients.
Cumbria Partnership Foundation Trust	Briefing paper	'Skin Assessment' Could we include a community based study rather than all hospital based?
Cumbria Partnership Foundation Trust	Briefing paper	'Staff training and numbers': Elements of non-compliance and limited availability to carers in the community which also impacts on pressure ulcer development. Would be interesting to have some community based views.
Cumbria Partnership Foundation Trust	Briefing paper	'Care Planning' Are we missing an opportunity to be proactive? How about care planning for patients 'at risk' rather than waiting until they are 'high risk'?
Cumbria Partnership Foundation Trust	Briefing paper	'Box 2: Nursing Red Flags' 'Minimised' Should we highlight the need to be regularly repositioned rather than just checking comfort? If patient comfortable, may be reluctant to reposition?
Cumbria Partnership Foundation Trust	Briefing paper	'Staff Training and Numbers' Maybe we need to give ownership to ALL clinical disciplines. It would be interesting to assess OT, Physio and Mental Health nurses knowledge. In community, the nurse may not be involved in that patients care, so OT, Physios etc need this knowledge. Hospital based study, not

Stakeholder	Comment on	Comments Please insert each new comment in a new row.
		community.
Cumbria Partnership Foundation Trust	Briefing paper	Should we state that if pressure ulcer present, sitting should be restricted to maximum 2 hours?
Cumbria Partnership Foundation Trust	Briefing paper	Provision of recliner chairs for patients with oedematous legs, will reduce oedema reducing risk of pressure ulcers to heels.
Cumbria Partnership Foundation Trust	Briefing paper	Deep tissue injury, ungradeable pressure ulcers. What about diabetic foot ulcers – are they pressure?
Cumbria Partnership Foundation Trust	Briefing paper	'NICE MGT17 Rec 1.3': It is unlikely you would use debrisoft on a wound suitable for larvae> Debrisoft would not be used on thick, attached slough?
Cumbria Partnership Foundation Trust	Briefing paper	'grading' We do not know how accurate our grading is. Some Trusts are reporting ungradeable and Deep tissue injury – others are not – how can we obtain accurate info? What about diabetic foot ulcers over bony prominences, with an element of pressure – are they pressure? What about patients with vascular compromise who acquire wounds over bony prominences? Are these reported by vascular nurses / diabetic nurses?

Stakeholders who submitted comments at consultation

- Alder Hey Children's NHS Foundation Trust
- British Association of Dermatologists
- British Association of Prosthetists and Orthotists (BAPO)
- British Geriatrics Society
- British Infection Association

- British Specialist Nutrition Association
- College of Occupational Therapists
- Cumbria Partnership Foundation Trust
- Department of Health
- Gloucestershire Hospitals NHS Foundation Trust
- Guys and St Thomas NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Medway Community Healthcare
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- NHS England (Midlands & East)
- Oxford Health NHS Foundation Trust
- Royal College of General Practitioners
- Royal College of Nursing

- Royal College of Paediatrics and Child Health
- Sheffield Teaching Hospital NHS Foundation Trust
- Society of Chiropodists and Podiatrists
- Tissue Viability Society