Professional Record Standards Body

Better records for better care

Nursing Care Needs Standard Consultation Survey Report

September 2023

Document Management

Revision History

Version	Date	Summary of Changes
0.1	06/09/2023	Initial version
0.2	12/09/2023	Updates after internal review
0.3	02/10/2023	Updated following change in project name

Reviewers

Reviewer name	Title / Responsibility	Date	Version

Approved by

Name	Title / Responsibility	Date	Version
Project Board		27/09/2023	0.2
Assurance Committee		28/09/2023	0.2

Glossary of Terms

Term / Abbreviation	What it stands for
CIS	Core Information Standard
CNIO	Chief Nursing Information Officer
EPMA systems	Electronic prescribing and medicine administration system
HCPC	Health and Care Professions Council
IDDSI	International Dysphagia Diet Standardisation Initiative
IV	Intravenous
LD	Learning disability
MUST	Malnutrition universal screening tool
NBM	Nil by mouth
NHS	National Health Service
NG	Nasogastric
NMC Register	Nursing and Midwifery Council Register
PEG	Percutaneous endoscopic gastrostomy
PRSB	Professional Record Standard Body
SALT	Speech and Language Therapy
SNOMED CT	Systemized Nomenclature of Medicine – Clinical Terms

TVN	Tissue Viability Nurse
UTIs	Urinary tract infections

Contents

1 Background

1.1 Introduction

This is an appendix to the final report for the Nursing Care Needs Standard project.

One online survey was distributed to nurses to gather quantitative and qualitative data to inform the further development of the draft project deliverable. The full list of survey questions is included in Appendix A.

1.2 Nursing Care Needs Standard

The Nursing Care Needs Standard is based on the PRSB's Core Information Standard (CIS), which sets out the structure and content of information that should be shared about a person in a shared care record. The CIS is made up of information components such as medications, investigation results, examination findings and assessments. Different standards can have different combinations of components identified through consultation. Where a component is included in a standard it is structured in the same way across all the standards so that the information can move between systems. The Core Information Standard is currently being implemented in Integrated Care Systems.

Where an information need was identified but a component did not exist in any existing PRSB standards, new definitions for the structure and content were created, for example for the Activities of Daily Living (ADL) sections, Skin, and Medication Self-Management.

The nursing specific sections are the following:

- Eating and drinking
- Mobility
- Elimination (Toileting and continence)
- Personal hygiene and dressing
- Skin
- Medication self-management

2 Methodology

2.1 Survey

Following the webinars, an online survey was conducted via SurveyMonkey. The questionnaire intended to gather qualitative and quantitative data to inform the further development of the standard. The PRSB Communications, Engagement and Strategy team distributed the link via all streams. Simple plain-text language, which described the nature of the project, its aims, and scope, and the format of the workshop, was used when sharing the survey. We forwarded this on through social media channels, through email, and through existing lists of people connected to nursing. We were able to make use of contacts within professional bodies and well-respected individuals in the field to drive interest in the webinar and gave them plenty of time to register in advance of the event.

The survey was open from Monday 1st August – Monday 21st August 2023.

The survey consisted of 4 parts:

1. **Demographic questions**: Questions that asked the respondent about their Nursing and Midwifery Council (NMC) registration, the setting they work in, and their job title.

2. **Proposed section elements review:** Respondents were presented with the proposed elements in each new section of the standard and asked to check any element that they felt did not belong in the standard.
3. **Missing elements in sections:** Respondents were provided with the opportunity to indicate whether they felt any crucial elements were missing from each section, and if so, they were given a free text box to elaborate.
4. **General feedback:** At the end of the survey respondents were given the opportunity to provide any final feedback on the standard in its entirety.

2.2 What the survey was

- For testing the content of the Nursing Care Needs Standard with the people who will use them by gathering evidence to support/ oppose the inclusion of existing sections and elements and to identify any new areas to incorporate as required.
- To better understand issues that may affect the implementation of the standards in the real world and the potential impact on people who will use them.
- A short and pragmatic exercise to engage stakeholders, including nurses and digital staff.
- A process where the number of responses was necessarily constrained by the focus on a limited condition (e.g., Registered Nurses), although a strength was that over 95% of respondents were registered nurses on the Nursing and Midwifery Council.

2.3 What the survey was not

- Designed to gather detailed characteristics (e.g., age, sex, or other potentially confounding factors) or generate conclusions about nurses.
  Caution should be applied when drawing inferences that may not be generalisable to the wider population of the UK and four nations. The information may be representative of the views of some or even many nurses, but it was not the intention of this exercise to draw conclusions beyond those relevant to guiding us in the development of the standard's content.

3 Survey respondents

The survey undertaken involved a comprehensive assessment of the data elements within each section. Participants were invited to critically evaluate the presence or absence of pertinent components. Additionally, they were encouraged to offer open-ended feedback and propose additional data elements suitable for both adults and children, which were the focal points across the three nursing settings in scope.

3.1 Respondent's demographic breakdown

A total of 483 responses were collected. 418 responses were fully analysed, after excluding potential confounders.

The majority (95.72%) of the respondents were registered nurses and/ or midwifes on the Nursing and Midwifery Council (NMC) register, and the remaining included individuals who were qualified nurses currently not registered, registered nursing associates, trainee nursing associates, currently on non-practicing registrations, health care professionals, Health and Care Professions Council (HCPC) registered, digital clinical systems developers and social work.

The majority (84.76%) of registered nurses worked with adults and 6.68% worked with children (Figure 1).

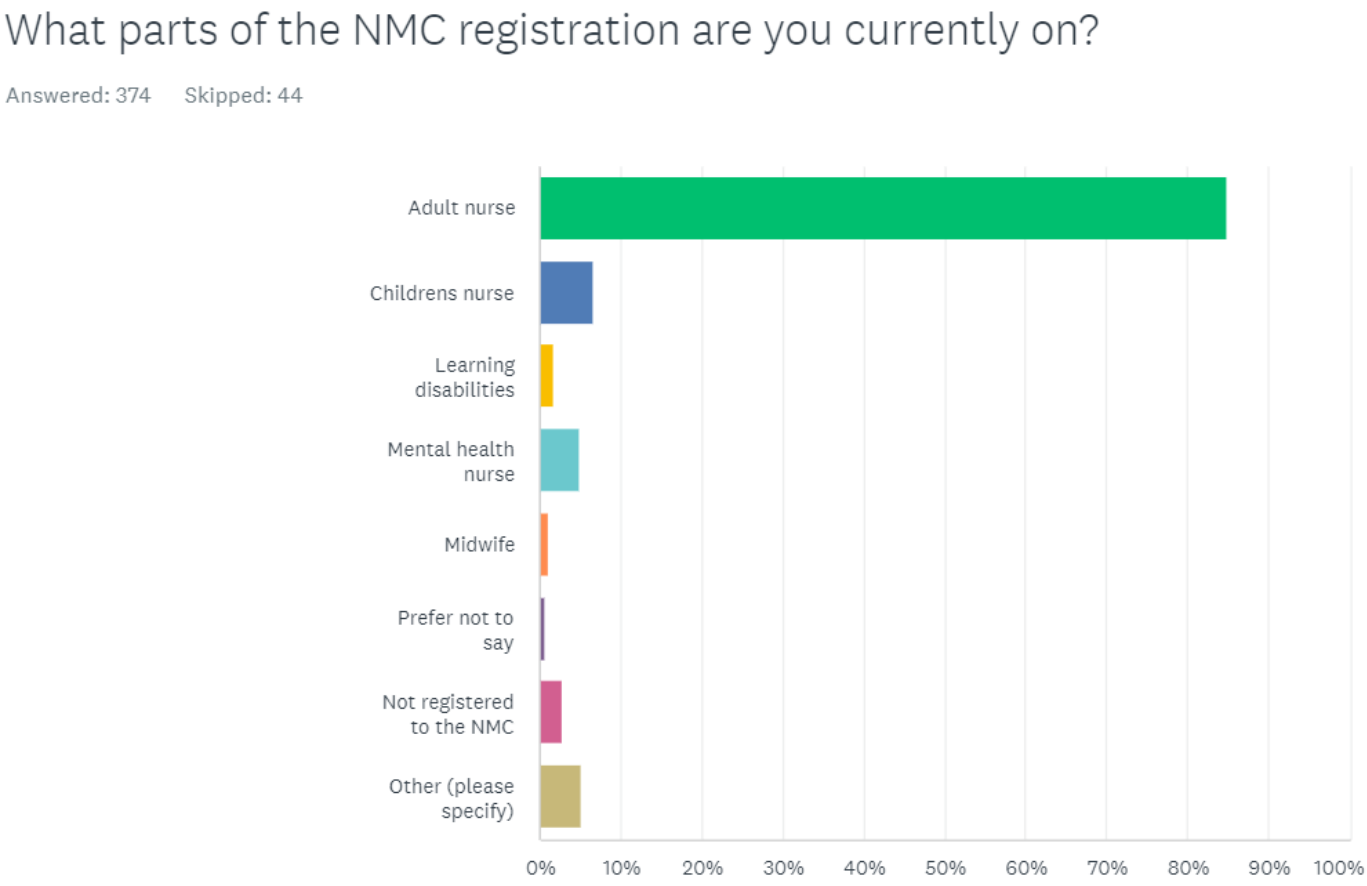

Figure 1. *shows how many nurses were registered as part of the NMC registration.*

Half (51.60%) of respondents reported to work in acute hospitals, and over a quarter (26.74%) worked in community care. The full list of reported workplaces is included in the appendix B.

3.2 Section-specific responses

3.2.1 Elements That are Candidates for Removal

Participants engaged with a specific question at each section that prompted further comments/ feedback for each section. Firstly, participants were presented with the current list of elements in each section and asked to indicate any elements they felt did not belong. They were then given the opportunity to provide comments on the proposed section, as well as suggestions for elements to be added to the section. The response rates differed across the sections of the survey shown in table 1.

Section name	Percentage of responses to the question “Considering the above elements, do you think any elements are missing?” at each section (%)		
	Yes	No	Prefer to not say
Eating and drinking	33.94	62.92	3.13
Mobility	27.50	68.33	4.17
Elimination (Toileting and continence)	26.02	70.47	3.51
Personal hygiene and dressing	21.26	75.15	3.59
Skin	29.00	67.98	3.02
Medication self-management	29.81	65.84	4.35

Table 1. *A table displaying percentage of responses to the question “Considering the above elements, do you think any elements are missing?” at each section (%).*

Most respondents, shown in table 1, selected ‘No’ after considering if there were any data elements missing. This suggests that most nurses considered the data elements in each section were comprehensive and clinically relevant for the purpose of initial assessment upon admission for adults and children across the three settings in scope. There was a lack of a majority of responses towards removing a data element; therefore, no data elements were removed. However, the remaining comments/ feedback were analysed and considered internally.

3.2.2 Section-specific findings

A systematic thematic analysis revealed prevalent recurring themes from the participants' inputs. These thematic patterns subsequently informed a set of formulated recommendations for each respective section. The resulting insights, synthesised from respondents' viewpoints, is shown in Appendix C.

4 Limitations

- The survey was originally intended to run from Monday 1st August – Friday 18th August 2023. However, due to many relevant stakeholders on annual leave during the summer holidays and low engagement from paediatric and community nurses, the project board decided to extend the survey for three days until Monday 21st August 2023.
- A total of 13.46% of respondents (n = 65) were completely excluded, as they only recorded their names and organisations, but they did not answer the Nursing Care Needs Standard section questions. 9.10% of respondents (n = 44) were partially excluded from the overall demographic breakdown, due to no information recorded. However, their answers for the nursing data elements were captured and analysed.

All potential confounders were removed; however, caution was applied when drawing inferences, as the sample results may not be generalisable to the wider population of the UK.

5 Conclusions and recommendations

The outputs from the survey were used to refine the standard and inform some of the project recommendations. These are discussed further in the main body of the project final report.

6 Appendix A – Survey questions

Who we are

We are the Professional Record Standards Body (PRSB), a dedicated organisation that develops information record standards to ensure the right information is shared wherever and whenever care is needed. Our unique network consists of professionals, patients, and the public who collaborate to make joint decisions on safely and effectively sharing crucial information.

Purpose

This survey is part of a project, commissioned by NHS England, which aims to improve the quality and consistency of nursing documentation, while also ensuring that the needs of patients and healthcare providers are met. It is a chance to determine what information needs to be shared among professionals to make sure that they can offer the highest quality of care possible.

This survey addresses information used during the first nursing care contact assessment. This includes issues and interventions such as how eating and drinking, mobility, elimination (toileting and continence), personal hygiene and dressing, skin, and medication self-management are recorded and shared in hospitals, community settings, and nursing homes.

We have developed a draft of how this information may be recorded, and this survey will ask for your feedback on whether you think what we have developed reflects everything you would need to know or would want to be recorded/shared.

The care settings in scope for this standard include Hospitals, Community care, and Nursing homes. Adults and Children are in scope for this standard.

Mental Health nursing, midwifery and neonatal care are out of scope for this project.

You do not need to provide identifying/personal information, however it would help us if you could tell us about your role and the type of provider that you work for, so we can ensure the needs of all nursing professions as well as people who receive care are represented in the final standard.

This survey will take approximately 10 minutes.

Your feedback is crucial to us in achieving our shared goal of promoting better patient care, improved healing, and enhanced care experiences. We greatly appreciate your participation and insights, as they will contribute to making a significant positive impact on nursing documentation, patient safety, and overall healthcare quality. Thank you for taking the time to participate in this important survey.

* 1. Are you a registered nurse and/ or midwife (e.g., on Nursing and Midwifery Council [NMC] register)?

- ◯ Yes
- ◯ No (Please describe your nursing status - e.g. qualified nurse not currently registered)

* 2. What parts of the NMC registration are you currently on?

- ☐ Adult nurse
- ☐ Childrens nurse
- ☐ Learning disabilities
- ☐ Mental health nurse
- ☐ Midwife
- ☐ Prefer not to say
- ☐ Not registered to the NMC
- ☐ Other (please specify)

* 3. In which of the following sectors are you employed? (Please select all that apply)

- ☐ NHS
- ☐ Independent care provider setting
- ☐ Local authority
- ☐ Other (please specify)

* 4. Where do you work? (Please select all that apply)

- [ ] Acute hospital
- [ ] Ambulance
- [ ] Community care
- [ ] Children's hospital
- [ ] 111 service
- [ ] Urgent and emergency care
- [ ] Hospice
- [ ] Nurse care home
- [ ] Primary care
- [ ] Mental health/ Learning disability hospital
- [ ] Residential care home
- [ ] Assisted living
- [ ] Local authority
- [ ] Specialist centre
- [ ] Other (please specify)

* 5. What is your job role?

- [ ] Community Nurse
- [ ] Inpatient Ward Nurse
- [ ] Outpatient Nurse
- [ ] Nurse Consultant
- [ ] Nurse Practitioner
- [ ] Nurse Manager
- [ ] Care Home Manager
- [ ] Care Home Nurse
- [ ] Director/Assistant Director of Nursing
- [ ] CNIO
- [ ] Prefer not to say
- [ ] Specialist Nurse (Please indicate specialism)

6. If your job role is different than the options listed above, then please indicate the your job role in this box.

Nursing sections

The following questions are about the proposed sections that will be recorded at initial assessment upon admission.

The proposed Nursing sections are the following:

1. **Eating and Drinking**
2. **Mobility**
3. **Elimination (Toileting and Continence)**
4. **Personal Hygiene and Dressing**
5. **Skin**
6. **Medication Self-Management**

You will be asked some questions about each section to understand whether they contain the appropriate information that you would need and want to see included.

Eating and Drinking Section

Below you will see the proposed elements in The Eating and Drinking section. In bold is the element name, and next to it is a description of the element.

7. Please tick any items that are **NOT** needed in the Eating and Drinking section.

- [ ] **Eating and drinking capability -** Information regarding whether the person is capable of, and typically attends to their own, eating and drinking needs. If the person is a child then indicate whether this is in line with their developmental age.
- [ ] **Weight -** The persons weight.
- [ ] **Weight measurement position -** The position of the person when measuring their weight (e.g. standing, sitting, wheelchair).
- [ ] **Height/length -** The person's height and length measurement.
- [ ] **Body Mass Index (BMI) -** The person's BMI calculation.
- [ ] **Unintentional weight loss -** A report on unintentional significant weight loss in the past six months.
- [ ] **Problem(s) with drinking fluids -** Problem that the person has with drinking fluids.
- [ ] **Problem(s) with eating -** Problem that the person has with eating food.
- [ ] **Feeding equipment and support -** A record of any assistance required to eat independently or not independently. Any aids used to support an individual to eat and drink independently. E.g. a plate guard, adapted cutlery, spill-proof cups.
- [ ] **Tube feeding -** The details of tube feeding. E.g. Gastrostomy, jejustomy, naso gastric tube, enteral and parenteral eating and drinking.
- [ ] **Individual nutrition requirements** - The nutritional requirements of an individual. E.g. fluid restrictions
- [ ] **Hydration -** Details of an individual's hydration state.
- [ ] **Dental device -** Dental device used by the person.
- [ ] **Does the person have their dental device with them? -** An indication for whether the individual has their dental device with them.
- [ ] **Mouth health's effect on eating and drinking -** Whether the condition of the person's mouth health affects their ability to eat and drink
- [ ] **Experience of nausea and vomiting -** Indication of whether the person is experiencing nausea and vomiting.
- [ ] **Dietary requirements -** The details of an individual's dietary requirements, this includes religious requirements.
- [ ] **Likes and dislikes -** A description of things the person likes e.g. particular foods or drinks
- [ ] **Preferred eating times -** An indication of the times that the individual prefers to eat at.
- [ ] **Sensory preferences -** The sensory preferences of the person. This could include preferred food textures.
- [ ] **Appetite -** A record of the person's desire or inclination to eat. This includes information about factors that can influence appetite, such as hunger, satiety, food preferences, and eating behaviours. This can be used to identify any changes or abnormalities that affect their nutritional intake and health.
- [ ] **Infant and young child feeding status -** The feeding status of the person if they are an infant or young child. This will include whether they are breast or bottle fed, what type of food they eat etc.
- [ ] **Comments -** Any further comments relating to eating and drinking.

* 8. Considering the above elements, do you think any elements are missing?

Please consider both adults and children, and the following care settings when considering your answer:
-Hospitals
-Community care
-Nursing homes

- ◯ Yes (Please specify what you think is missing in the comment box below)
- ◯ No
- ◯ Prefer not to say

What is missing? Any other comments?

Mobility Section

Below you will see the proposed elements in The Mobility section. In bold is the element name, and next to it is a description of the element.

9. Please tick any items that are **NOT** needed in this Mobility section.

- [ ] **Baseline mobility -** The record of what is normal mobility for the patient prior to admission.
- [ ] **Mobilisation in line with developmental stage -** An indication of whether the individual is mobilising in line with their developmental stage.
- [ ] **Sit to stand -** The level of assistance that the person require to transfer from the sitting to standing position.
- [ ] **Ability to move between two spaces -** An indication for whether the individual is sufficiently mobile to move between spaces. E.g. bed, bedroom, toilet, chair and kitchen. This includes lateral transfers.
- [ ] **Type of transfer support needed -** Whether the individual requires transfer support and the type of support needed.
- [ ] **Patient positioning -** The position that the patient is required to be placed in to ensure comfort and safety.
- [ ] **Mobility aid -** The mobility aid of the person that allows movements between two space and achieves participation and a degree of independence.
- [ ] **Mobility aid dependency -** An indication of the total usage and dependence on the mobility aid of the person.
- [ ] **Number of staff required to assist with mobilisation -** A record of the number of staff required to assist with mobilising the patient.
- [ ] **Unexplained falls -** Identification of unexplained falls of the person.
- [ ] **Experience of faints, fits, or disorientation -** A description of whether the person has any experience of faints, fits, or disorientation.
- [ ] **Recent changes in balance -** A report on recent changes in the person's ability to safely balance that may increase the risk of falls.
- [ ] **Falls in the past 12 months leading to significant injury -** Any falls that the person has had in the past 12 months that has lead to significant injury.
- [ ] **Fear of falling -** A person's belief in their ability to undertake certain activities of daily living without falling or losing balance.
- [ ] **Night sedation -** An indication if the person has been prescribed night sedation.
- [ ] **Use of cot sides -** A record for the use of cot sides fitted to a bed to stop the patient from falling out of bed.
- [ ] **Problems affecting mobility -** A record of any problems experienced that impacts the patient's ability to fully mobilise. This can include physical and psychological conditions that impair full independent mobilisation.
- [ ] **Memory/ mood -** A record of the person's memory/ mood that may impact their mobility and risk of falling.
- [ ] **Observed delirium -** A record if the patients appears to experiencing two or more symptoms of delirium.
- [ ] **Observed frailty -** A record of any symptoms of frailty observed by the professional.
- [ ] **Footwear, hosiery, and care -** A record if the person has the appropriate footwear with them that is suitable for their environment.
- [ ] **Mobility following surgery -** A record of the person's mobility level following surgery, if the person has had recent surgery.
- [ ] **Changes in mobility -** A record completed by the person or guardian/ carer(s)/ professional contact in any changes to the person's mobility.
- [ ] **Comments -** Any further comments relating to mobility.

* 10. Considering the above elements, do you think any elements are missing?

Please consider both adults and children, and the following care settings when considering your answer:
-Hospitals
-Community care
-Nursing homes

- ◯ Yes (please specify what you think is missing in the comment box below)
- ◯ No
- ◯ Prefer not to say

What is missing? Any other comments?

Elimination (Toileting and Continence)

Below you will see the proposed elements in The Elimination (Toileting and Continence) Section. In bold is the element name, and next to it is a description of the element.

11. Please tick any you think are **NOT** needed in the standard.

- [ ] **Elimination capability -** Information regarding whether the person is capable of, and typically attends to their own, elimination needs.
- [ ] **Problems or concerns with bowels -** Any problems or concerns that the patient has in regard to their bowels.
- [ ] **Typicality of bowel problem -** An indication of whether the person's problems with their bowels are typical for them.
- [ ] **Frequency of bowel opening -** The frequency of how often the person opens their bowls. This can be across different periods of time.
- [ ] **Last bowel opening -** The last time the person opened their bowels.
- [ ] **Usual stool consistency -** The usual consistency of the person's stool. Bristol's stool chart should be used to complete this item.
- [ ] **Problems or concerns with urination -** Any problems or concerns that the patient has in regard to urination or their urine.
- [ ] **Typicality of urination problem -** An indication of whether the person's problems with urination are typical for them.
- [ ] **Urinary retention or residual bladder volume -** An indication of whether the person experiences urinary retention or residual bladder volume.
- [ ] **Incontinence -** A record of whether the person experiences incontinence.
- [ ] **Requirements for toileting assistance -** Any requirements the patient has for toileting assistance. E.g. wiping self, handwashing.
- [ ] **Relevant medication -** Any medication relevant to the person's elimination needs. E.g. stool softeners, laxatives, iron supplements.
- [ ] **Use of continence equipment -** Whether the person uses incontinence equipment, such as pads, belts, or nappies.
- [ ] **Community delivery of continence equipment -** Whether the person is receiving continence equipment from community delivery.
- [ ] **Continence equipment required -** The continence equipment required to support the individual.
- [ ] **Commode or raised toilet seat requirements -** Whether the person requires a commode or raised toilet seat.
- [ ] **Requires ordering commode or raised toilet seat -** Whether the person requires ordering a commode or raised toilet seat, if they require using one.
- [ ] **Catheter, bowel, and stoma medical devices -** An indication of whether the person has any medical devices to support with catheter, bowel, or stoma care. (For example, colostomy, catheter etc.).
- [ ] **Reason for stoma -** The reason for the person's usage of a stoma.
- [ ] **Reason for catheter -** The reason for the person's usage of a catheter.
- [ ] **Self-management of catheter -** Describe the person's management of a catheter, whether they self-catheterise or require support.
- [ ] **Usage of catheter -** This describes the person's usage of a catheter is intermittent, full-time or part-time and the reasons why.
- [ ] **Comments -** Any further comments relating to elimination (toileting and continence).

* 12. Considering the above elements, do you think any elements are missing?

Please consider both adults and children, and the following care settings when considering your answer:
-Hospitals
-Community care
-Nursing homes

- ◯ Yes (please specify what you think is missing in the comment box below)
- ◯ No
- ◯ Prefer not to say

What is missing? Any other comments?

Personal Hygiene and Dressing Section

Below you will see the proposed elements in The Personal Hygiene and Dressing section. In bold is the element name, and next to it is a description of the element.

13. Please tick any that you think are **NOT** needed in the standard.

- [ ] **Personal hygiene and dressing capability -** Information regarding whether the person is capable of, and typically attends to their own, personal hygiene needs. E.g. washing, showering, bathing, dressing, mouth care, foot and nail care, other. If the person is a child then indicate whether this is in line with their developmental age.
- [ ] **Problems affecting personal hygiene and dressing -** Any problems that may affect a person's ability to wash or dress, e.g., stroke, weakness, arthritis.
- [ ] **Personal hygiene and dressing support needs -** Details of any support needed for personal hygiene.
- [ ] **Equipment to aid personal hygiene and dressing -** Information about any equipment the person uses to support personal care.
- [ ] **Equipment with person -** An indication of whether the person has brought their equipment with them.
- [ ] **Condition of mouth -** Information on whether the person's mouth is feeling moist, clean, and comfortable. E.g. no pain, not dry, no soreness.
- [ ] **Capability to maintain mouth hygiene -** An indication on whether the person is able to clean their teeth, dentures, and mouth without assistance.
- [ ] **Problems with hands and fingers -** An indication of whether the person has problems with their hands and fingers. If they have problems with their feet, information about the problems should be included.
- [ ] **Problems with feet -** An indication of whether the person has problems with their feet. If they have problems with their feet, information about the problems should be included.
- [ ] **Nails -** Indication of the condition of the person's nails.
- [ ] **Normal home personal hygiene and dressing routine -** A description of the person's normal personal hygiene and dressing routine at home.
- [ ] **Preferences -** Any preferences the person has regarding personal hygiene and dressing. This may include product preferences, preference of bath/shower, carer gender preferences, clothing preferences etc.
- [ ] **Shaving -** Any requirements a person has in relation to shaving. This could be for facial or body hair. This may include whether they prefer to shave or not, and where they wish to be shaved.
- [ ] **Impact of medication on personal hygiene and dressing -** Any impacts of a person's medication on their personal hygiene and dressing. E.g., sweating.
- [ ] **Religious and cultural considerations -** Any religious or cultural requirements that need to be considered when delivering care.
- [ ] **Comments -** Any further comments relating to personal hygiene and dressing.

* 14. Considering the above elements, do you think any elements are missing?

Please consider both adults and children, and the following care settings when considering your answer:
-Hospitals
-Community care
-Nursing homes

- ◯ Yes (please specify what you think is missing in the comment box below)
- ◯ No
- ◯ Prefer not to say

What is missing? Any other comments?

Skin Section

Below you will see the proposed elements in The Skin section. In bold is the element name, and next to it is a description of the element.

15. Please tick any that you think are **NOT** needed in this standard.

- [ ] **Skin integrity -** Initial assessment of the person's skin integrity.
- [ ] **Existing skin problems -** Any record of any skin conditions. E.g. dermatitis, psoriasis.
- [ ] **Details of previous skin problems -** A description of any previous skin problems, including when, causes, treatment and scarring etc.
- [ ] **Use of ointments/ creams -** The name of ointment/ creams used to maintain skin integrity.
- [ ] **Wound care products -** Types of wound care products used by the person.
- [ ] **Analgesia products -** Name of analgesia products used by the person.
- [ ] **Signifiers of poor circulation -** Any information that may signify poor circulation in the person, such as: pale/blue skin, pins and needles sensations, cold fingers or toes etc.
- [ ] **Experience of acute or chronic pain -** Information about any acute or chronic pain that the individual is experiencing.
- [ ] **Wheelchair effect on skin -** Any effects that the person's wheelchair has on their skin. This data item may be used to record any current effects of the wheelchair, or potential effects the current condition of the wheelchair may have.
- [ ] **Devices effect on skin -** Any effects that the person's devices has on their skin. This data item may be used to record any current effects of a device, or potential effects the current condition of the device may have.
- [ ] **Footwear/ clothing effect on skin -** Any effects that the person's footwear or clothing has on their skin.
- [ ] **Medication affecting skin -** Any medications that the person uses and their side effects on the person's skin. E.g., sweating, drying out skin.
- [ ] **Effect on skin -** The effect the medication has on the skin.
- [ ] **Ability to alter own position -** The ability of the person to alter their own positioning.
- [ ] **Comments -** Any further comments relating to skin.

* 16. Considering the above elements, do you think any elements are missing?

Please consider both adults and children, and the following care settings when considering your answer:
-Hospitals
-Community care
-Nursing homes

- ○ Yes (please specify what you think is missing in the comment box below)
- ○ No
- ○ Prefer not to say

What is missing? Any other comments?

Medication Self-Management Section

Below you will see the proposed elements in The Medication Self-Management Section. In bold is the element name, and next to it is a description of the element.

17. Please tick any that you think are **NOT** needed in this standard.

- [ ] **Medication present with person -** Information about whether the person has brought their medication with them.
- [ ] **Usual administrator of medication -** The individual that usually administers the person's medication. This may be themselves, or another person.
- [ ] **Usual administrator of medication at nursery/ school/ college -** The individual that usually administers the young person's medication at nursery/school/college. This may be themselves, or another person.
- [ ] **Ability to self-administer -** An indication of whether the person is able to self-administer their own medication.
- [ ] **Medication organisation equipment -** Information about any medication organisation equipment that the person has. E.g. a pill / medication organiser / Dosette box / multi-compartment compliance aid.
- [ ] **Time of last medication administered -** A record of when the person last took their medication independently or administered by staff/ carer.
- [ ] **Problems affecting medication management -** A record of any problems that may impact the patient's ability to take medication, such as patient dexterity and visual limitations in relation to personal administration of medications.
- [ ] **Comments -** Any further comments relating to medication self-management.

* 18. Considering the above elements, do you think any elements are missing?

Please consider both adults and children, and the following care settings when considering your answer:
-Hospitals
-Community care
-Nursing homes

- ◯ Yes - please specify in comment box
- ◯ No
- ◯ Prefer not to say

Any comments?

Any other comments

19. Please include any other thoughts/ comments on the overall Nursing (Initial Assessment) Standard.

* 20. How did you hear about the development of the PRSB's Nursing (Initial assessment) Standard?

* 21. Would you like to:

- [ ] Receive further updates on this project via email
- [ ] Receive updates on other PRSB projects via email
- [ ] Potentially follow up on the answers you have provided in this survey
- [ ] Receive invitations to join other PRSB projects
- [ ] Subscribe to PRSB's monthly newsletter
- [ ] None of the above

22. Please enter your contact details below, if you indicated that you wished to be contacted in the previous question. **(Please note that this will mean your response is not anonymous, however if we reference any of your answers in our reporting we will not link it to your personal data.)**

Name	
Organisation	
Email Address	

Thank You

Please click "Done" below to submit your responses. Your responses will not be submitted until you do this.

If you want any further information about the PRSB or the Nursing (Initial Assessment) Standard, please contact info@theprsb.org, or visit our website.

Thank you for taking part in our survey.

7 Appendix B – SurveyMonkey outputs

Please find the raw SurveyMonkey output, of all 483 responses, with no identifiable information **here.**

Please find the SurveyMonkey quantitative output **here**.

8 Appendix C - A table displaying the most frequent themes and actions/ recommendations for the sections of the Nursing Care Needs Standard

The list of quotes under 'Findings' are not extensive, and the full details of all respondents' comments can be found in Appendix B.

Section	Suggested missing themes	Comments	Actions/ Recommendations
Eating and drinking	**Alcohol intake** There were some comments that raised that alcohol habits/ consumption should be assessed at initial assessment.	"alcohol habits" - *Advanced Nurse Practitioner / Senior Nurse* "alcohol consumption…" - *Digital nurse*	There is a data element to capture the person's Risks; if alcohol intake/ consumption is considered as a Risk by the nurse at initial assessment, it can be captured within the CIS section.
	Allergies and intolerances Allergies and intolerances, and special diets, were frequently mentioned by nurses with various background.	"food allergies and restrictive diet e.g. gluten free, renal diet" - *CNIO* "severity of allergy" - *Intensive Care (ICU)*	This is captured in the Allergies and Adverse Reactions section of the CIS.
	Who is responsible for food/ how is food collected The responsibility of food and how it was collected and prepared was stressed by several respondents, as people can have inaccurate self-	"can they prepare food…" - *Director/Assistant Director of Nursing* "how do they get food and prepare it for example the patient may say they eat well and what	The suggested additional elements have been considered in the previous iterations of the standard; however, it was considered too specialised/ detailed for initial assessment. Although it was stressed that the data elements act as a proxy

	reporting which can lead to potential nutritional deficiencies.	they like but the cupboards are bare." - *Quality lead nurse* "the ability to shop, cook, prepare food etc" - *Community nurse*	assessment for mental capacity and responsibilities, which can be captured with the CIS sections, such as a social circumstances.
	IDDSI The IDDSI was stressed by many respondents, in relation to problems with eating and drinking.	"IDDS levels for prescribed thickened fluid and food modifications" - *Director/Assistant Director of Nursing* "IDDSI level/s patient may be on prior to admission to hospital/caseload" - *Nurse manager*	This is the responsibility of the provider and local system supplier to ensure they have the appropriate data value sets to ensure documentation of clinical practice is relevant.
	Mouth care Further granularity around mouth care was highlighted from some responses.	"Their oral hygiene routine, floss brush, Mouthwash etc. Whether they are independent with washing their hands before eating or if they need help." - *Adult nurse* "Whether the individual requires assistance in meeting those mouth care needs (unless you have covered elsewhere)" - *Adult nurse, Mental health/ learning disability hospital*	Repetitive questions will be identified and eliminated to streamline the assessment process.

	MUST Many respondents reported MUST should be included in the final section.	“MUST score on potential malnutrition” - *CNIO* “MUST malnutrition assessment (elements are included above but the tool needs to be)” - *TVN, Community care*	MUST assessments are out of scope at initial assessment. Further assessments are expected to be completed post-initial assessment.
	Nil-by-mouth (NBM)	“nil by mouth - date time of rv” - *Digital nurse* “1)Are they currently nil-by-mouth (this could be included in the Individual nutrition requirements section but is necessary for MUST calculation.” - *Rheumatology nurse*	Current NBM will be considered in the next iteration of the model.
	Referrals	“Onward referrals completed - date and time of referral EG to dietician” - *District nurse, Community care* “Any referrals to AHPs such as Dietitian and SLT” - *Urgent and emergency care nurse*	This is very important; however it is the responsibility of the system suppliers to ensure patient information is interoperable.
	Speech and Language Therapy (SALT)	“Positional requirements for patients under SALT care .. i.e.	This standard is not prescribing clinical practice; for best of

		patients may require a chin tuck when swallowing." - *Director/Assistant Director of Nursing* "some more specific S.A.L.T information." - *Safeguarding ICB*	practice, please refer to NICE guidelines.
	Sensory preferences There were several comments that raised concerns of capturing textured diets in the section.	"Texture and consistency of food and drink" - *Non NHS nurse* "Type of textured diet" - *CNIO*	Textures can be captured in Sensory preferences of the Eating and drinking section. However, this can also be captured in the About Me section from the CIS components; therefore, system suppliers must consider how to reduce duplication of data recording if it is completed elsewhere in the record.
	Unintentional weight loss Respondents reported there was ambiguity surrounding the definition of unintentional weight loss and intentional weight loss.	"Maybe whether any intentional weight loss" - *Nurse practitioner, acute hospital* "Whilst Height and Weight are important, we did not deem this as part of the nurse's initial assessment documentation as does not need to a be a nurse that does this, we would also advocate for one source of truth for this and not to have weight recorded in multiple places in a patients record. We felt	

		unintentional weight loss needed a clearer definition” - *Clinical Digital team*	
	Reducing Repetition There were several comments that raised that some data elements overlapped and could be condensed into fewer items. Furthermore, the nursing workflow and practice may capture several data elements in one question, if asked appropriately.	“Eating and drinking capability, problems with eating and drinking overlap. Likes and dislikes and preferred eating times and sensory preferences all overlap. 'Hydration status' is too broad to be useful. The assessment should follow a dietetics assessment” - *Practice Development Nurse* “The first question could cover off others, if asked correctly” - *Independent care provider setting, Acute hospital*	Repetitive questions will be identified and eliminated to streamline the assessment process. Questions that are closely related, will be merged into a single question, where appropriate. This consolidation simplifies the assessment while capturing essential information.
	Burden of recording This may result in institutional harm, as setting and resourcing may not be able to fulfil the enquired preferences, however it is important to record and down to localities to determine how to implement.	“Just a comment about the preferred times of eating - is it realistic to be able to 'service' this in large institutions. Asking the question may set expectations by the patient that may not be provided.” - *Digital Nurse Specialist (Chief Nursing Information Officer)*	It is the local implementors that will incorporate which data elements will be relevant to their setting, which will in hand prevent the burden of recording on nurses.

	Language The use of inconsistent language was highlighted as an issue from the responses, with the general language being adult-centric or clinically inappropriate.	"change language- 'feeding' to become 'eating'." - *Direct/ Assistant Director of Nursing* "Still feels very adult focused in the language used, infants are not able to feed independently and may require adaption due to cleft palate or co-occurring health conditions. Consider question relating to collecting contact details for subject matter experts / specialists involved in providing support e.g. infant feeding or feeding & eating disorder service." - *Acute hospital nurse*	Language and terminology will be updated in the next iteration of the information model.
Mobility	**Capturing the person's health/psychological condition(s) that impact on their mobility** The survey responses highlighted several health problems that restrict mobility, such as obesity, breathing difficulties, and the use of prosthetics, emphasising the need to consider specific health conditions in mobility assessments. Respondents also stressed the importance of assessing cognitive abilities and techniques to promote patient	"In respect to above, no concerns but need to re-emphasise documentation by exception in the world of paper and digital. Would also like to see standardised answers to support discrete data analytics. Standardising nursing documentation entry" - *Adult nurse, acute hospital* "Some patients such as those with JIA or other inflammatory conditions may have difficulty	There is already a data element to capture the person's health/psychological conditions that may increase their risk of falling and mobility.

	compliance with mobility tasks. Additionally, the survey acknowledges the impact of conditions like epilepsy and dementia on perception, cognition, and mobility.	walking and mobilising when in flare but not when under control, some ability to record best and worst would be useful. Also pain and early morning stiffness as well as duration of these symptoms” - *Digital nurse*	
	Person's concerns and Priorities Patients would feel more engaged in their care when they are involved in setting their own goals.	“shouldn't we be asking what matters, what is important to the person? - *Lead nurse (Older people)* “Goal setting and formula that helps staff to set goals from start of admission for example something Similar to JHP workflow” - *Digital project nurse*	There is already a data element, About Me and Personal Support & Care Plan, in the core information standard that captures the goals, concerns and priorities of the person.
	Medication's Influence on Mobility and Fall Risk A number of survey responses suggests the need for the addition of medication review, especially in cases of polypharmacy, to identify and address medications that may increase the risk of falls. This emphasises the importance of	*Are they prescribed more than 5 medications? polypharmacy will increase chance of falls. Are they taking high risk medications (opiates, sedatives etc)* - *Quality matron*	Medication review typically falls within the purview of a prescriber's responsibilities.

	considering the effects of medication on patient safety and mobility during initial nursing assessment.	*Re night sedation - this should be wider to include any medication that may impact on mobility, e.g., and meds with sedation impact at any time, and cumulative effects.* - *Mental health nurse*	
	Consistent and Appropriate Language Many comments emphasised the importance of using the term "bed rails" instead of "cot sides" in clinical documents. There is a strong preference for consistent and appropriate language to describe safety measures for patients, particularly in the context of adult care.	*"Cot sides is not a phrase routinely used anymore in adult services. This should be more inclusive i.e., bed rails"* - *Clinical educator*	All terminologies highlighted in the responses would be updated to reflect modern practices and standards.
	Postural drop risk blood pressure check Respondents stated the significance of blood pressure monitoring, especially when transitioning between positions like standing to sitting or lying down. This monitoring plays a critical role in detecting postural drop, where blood pressure significantly decreases with changes in position. Identifying postural drop is crucial, as it is	"Lying and standing blood pressure monitoring during the initial assessment to identify postural hypotension which is one of the cause of falls." - *Nurse manager* "Lying and standing blood pressure to identify any deficit and help minimise falls" - *Nurse manager*	

	associated with an elevated risk of falls.		
	Reducing Nursing documentation burden Some respondents emphasised the pressing need to reduce the documentation burden on nurses. This includes suggestions to integrate with other clinical systems to prepopulate information (e.g., night sedation captured by EPMA systems), eliminate repetition (e.g., merging frailty and mobility questions), merge related questions (e.g., combining unexplained falls and falls in the past 12 months).	"Night sedation should not be uniquely captured; this should be captured by any good EPMA system and therefore should not be a requirement of the nurse to recapture this information when assessing a patients mobility." - *Adult nurse, acute hospital* "Some questions seem repetitive with regards to sitting to standing, mobilising, transferring. Think some of the above questions could be merged i.e., unexplained falls and falls in past 12 months to reduce the number of questions staff must ask." - *Adult nurse, acute hospital*	Concerns regarding the documentation burden on nurses, the proposed solutions include: - Integration with Clinical Systems: It will be captured in the implementation guidance on the need for Integration with existing clinical systems to prepopulate information whenever possible. For instance, data from Electronic Prescribing and Medication Administration (EPMA) systems can automatically capture night sedation details, reducing the need for manual data entry. - Elimination of Repetition: Repetitive questions will be identified and eliminated to streamline the assessment process. For example, merging questions related to frailty and mobility can reduce redundancy and make the assessment more efficient.
Elimination	**Comprehensive data collection**	"if it is long term or short term use and when the next change is	Catheter management is overseen by specialist, and the data captured in the core information standard.

	Respondents underscored the importance of collecting comprehensive and holistic information regarding a patient's elimination and continence requirements. It extends beyond merely identifying the presence of medical devices and includes the duration of their use, the schedule for replacements, and the proper storage of essential documents like catheter passports.	due plus where the catheter passport is kept." - *Director/Assistant Director of Nursing* "Supply and delivery of incontinent devices. Frequency of change of devices" - *Nursing associate* "Date of catheter insertion and when a change is due. Date of nephrostomy insertion and when this change is due. Concerns about stool or urinary tract infections, have samples been sent for testing Stool and urine colour, are these normal for the patient or do they indicate infection/dehydration" - *Digital nurse*	
	Dietary and Fluid Considerations Some respondents stated that dietary choices significantly impact urinary and bowel patterns. Therefore, the assessment should inquire about dietary influences and daily fluid intake to provide healthcare	"The "Elimination (Toileting and Continence)" section provided is comprehensive. However, for clarity, to avoid data duplication, and to ensure person-centred care in alignment with standards, consider the following suggestions: Include: 1. Dietary Impact: A record of	Data requested will be recorded in the nutrition assessment following this initial assessment.

	providers with a comprehensive understanding of the patient's elimination habits, enabling more informed care decisions.	whether the person's diet impacts their elimination patterns. Some foods and beverages can act as natural diuretics or constipating agents. 2. Fluid Intake: A record of the average daily fluid intake. This can directly influence urination patterns and can be useful data in conjunction with other elimination records." - *Clinical IT facilitator*	
	Self-management and carer involvement Evaluating the patient's ability to self-manage conditions such as stomas is pivotal. Determining whether patients can independently manage their condition or require support allows for the tailoring of care plans accordingly. Furthermore, acknowledging the role of caregivers, both within and outside the hospital, ensures the continuity of care.	"Self-management of stoma - Describe the person's management of their stoma, whether they are independent or require support and what level of support they require." - *Adult nurse* "Carer input outside of hospital and agreement re ongoing involvement whilst in patient." - *Head of nursing*	This will be captured in the patient's care plan and will be captured in the Core Information Standard.
	Medication and health conditions Respondents stated the importance of documenting medications that may affect elimination. It also considers the impact of specific health	"Kidney health e.g., CKD (and what stage). Especially vital if the patient is normally anuric. Whether the patient is on a fluid balance chart or fluid restriction." - *CNIO*	Drugs that may affect elimination will be captured in the Medication section.

	conditions, such as urinary tract infections (UTIs), gastrointestinal disorders, or neurological conditions, on continence.	"Family history of bowel cancer/prostate cancer? evidence of Benign prostatic hyperplasia? History of constipation - especially in learning disability population. Pelvic floor problems in women?" - *Adult nurse*	
	Reducing nursing documentation burden To enhance efficiency, respondents suggested strategies to reduce the data entry burden on healthcare professionals. This includes prepopulating data from existing records and consolidating sections to minimise redundant input.	"Relevant medication should be pulled through from drug chart e.g., catheter, stoma etc, can be included but should be connected to line, drain, tube assessment to avoid duplication of documentation." - *Practice development nurse* "Medication would be recorded in drug history and prescription. Does it need to be duplicated here?" - *CNIO*	Concerns regarding the documentation burden on nurses, the proposed solutions include: - Integration with Clinical Systems: It will be captured in the implementation guidance on the need for Integration with existing clinical systems to prepopulate information whenever possible and reduce the need for manual data entry, e.g., EPMA system automatically capturing medications, which will reduce the need for manual data entry. - Elimination of Repetition: Repetitive questions will be identified and eliminated to streamline the assessment process.

	Inappropriate terminology Respondents stated the importance of using respectful and appropriate terminology. It advocates for the use of precise terms like "continence" rather than vague phrases like "elimination capability" to accurately describe patients' conditions.	“Can you just use the term elimination and continence (rather than toileting?)” - *Nurse Manager* “Term nappies not appropriate for adults.” - *Practice Development Facilitator* “to change the language of 'toileting' to 'helping to the toilet' or assisting the person who has been to the toilet' to change language from 'nappies' to fully absorbent pad' or 'incontinence pants'” - *Director of nursing*	All terminologies highlighted in the responses would be updated to reflect modern practices and standards.
	Communication and mental capacity Assessing the patient's communication abilities and mental capacity is vital, especially for individuals with cognitive impairments or neurodiverse conditions. Understanding a patient's cognitive functioning enables healthcare professionals to tailor	“Mental capacity act and executive functioning. other diagnosis impact e.g. dementia, learning difficulty, autism etc.” - *Health visitor*	This covered in the core information standard.

	their communication and care approach appropriately.		
Personal Hygiene and Dressing	**Data Duplication and Repetition** Several comments suggest merging or eliminating questions related to oral hygiene, as they may be repetitive or better addressed in eating and drinking. Several comments also suggest combining questions related to problems with hands and feet.	"Hands and feet should incorporate any amount of reduced mobility. i.e. person with bad back may have use of hands and feet but would still require assistance in this domain." - *Adult Nurse / Tissue Viability Nurse* “Merge questions where appropriate and check that there isn't duplication across the different fields i.e. mouthcare in hygiene and hydration” - *Adult Nurse / CNIO*	Duplication across sections will be double checked. If elements are duplicated, then the duplication will be removed. Elements that can be combined into one item, and instead have a larger value set, will be combined where possible.
	Personal Preferences Questions related to personal preferences, such as product preferences, clothing preferences, and hair care preferences, were highlighted.	“products the patient prefers not to use due to lifestyle choices i.e. vegan” - *Adult / Digital Nurse* “Clothes preferences” - *Mental Health Nurse / Nurse Education Advisor* “what is their preference for clothing” - *Adult Nurse*	There is already an element to capture any preferences the person has, so no action is needed.
	Skin Conditions A few comments emphasize the need to include questions about	“Skin Condition: General skin condition, presence of rashes, sores, or any other skin	This can be captured by the element ‘Problems affecting personal hygiene and dressing’,

	skin conditions and their impact on dressing and hygiene routines.	problems that might be influenced by personal hygiene." - *Adult Nurse / Inpatient Ward Nurse / Clinical IT Facilitator* "Need to ensure captured here or in skin section: Skin conditions impact on ability to dress e.g. compression bandages or hosiery, NPWT or application of topical treatments for infections - scabies, MRSA." - *Adult Nurse / Childrens Nurse / Infection Prevention and Control*	use the patient's problem list as a value set. Another element could be added to further specify how the problem impacts them.
	Religious and Cultural Considerations Combining and removing religious and cultural needs was mentioned by some participants.	"Preferences" and "Religious and cultural considerations" could be merged to further simplify the standards." - Adult Nurse / CNIO "Religious needs can be covered by personal hygiene support needs." - Adult Nurse / Nurse Manager / Practice Development Nurse "cultural consideration can be given but what can be done if they prefer males but only females on all shifts?"	Religious and cultural considerations will be removed as a stand-alone element, and instead merged with the preferences element. It will be highlighted in the description that this is where religious and cultural considerations should be captured.

		- *Inpatient Ward Nurse*	
	Capability / Effect of Other Comorbidities Questions about an individual's capability to perform self-care tasks, including dressing, oral care, and hair care, were noted. May be affected by co-morbidities.	"Capability - awful word. How do we record individual patient ability, independent, requires some assistance, etc" - *Adult Nurse / CNIO* "Cognition / communication - distressed behaviours during care giving" - *Adult Nurse / CNIO* "Mental capacity act and executive functioning. other diagnosis impact e.g. dementia, LD, autism etc." - *Adult / Children's Nurse / Health Visitor*	The use of the word 'capability' across the standard will be reconsidered. The effect of other comorbidities should be captured by the element 'Problems affecting personal hygiene and dressing', use the patient's problem list as a value set. Another element could be added to further specify how the problem impacts them.
	Caregiver Input Information about any input that carers may have on personal hygiene and dressing.	"Carer input outside of hospital and agreement re ongoing involvement whilst in patient" - *Adult Nurse / Nurse Manager / Head of Nursing* "Care completed by parent/carer e.g. infant /young child" - *Children's Nurse / CNIO*	An element could be added to capture what facets of personal hygiene and dressing are completed by a caregiver for the person.
Skin	**Pressure Ulcer Assessment/Prevention** Many comments focused on assessing and preventing	"documented risk of pressure ulcer - using purpose T as all area will be moving to using this assessment tool"	This is not necessary for an initial assessment, and the PRSB Wound Care Standard can be used to capture this information.

	pressure ulcers, including the use of pressure-relieving equipment and risk assessments.	- *Adult / Tissue Viability Nurse* “assessment if at risk of pressure ulcers - Purpose T” - *Adult Nurse / Nurse Manager* “Pressure ulcer history.” - *Adult / Tissue Viability Nurse*	
	Medication Some comments highlighted that elements relating to medication would not be relevant, as they are in other parts of the patient record.	“Use of ointments/ creams, analgesia products and experience of acute or chronic pain - should be included in the medication section” - *Adult Nurse / Digital Nurse Practitioner* “The medication elements could be separate as that can be managed by the EPMA/ pharmacy team and alert the nursing teams in their documents of anything worth noting” - *Adult Nurse / CNIO*	Elements that would otherwise be recorded in the medication and medical devices section will be removed following consultation with clinical leads to reduce duplication of information.
	Skin Integrity and Care Some comments revolved around assessing and caring for the skin, including aspects like skin type, hydration, moles, and visual inspection.	*“*Skin Colour: Document any abnormal skin colours, which can indicate issues such as jaundice, cyanosis, erythema, or pallor.”	Skin integrity is currently the condensed version of multiple elements that included skin colour, bruising etc. This could be expanded again into a few more relevant elements, or the value set and description developed to

		- *Adult Nurse / Inpatient Ward Nurse / Clinical IT Facilitator* "Jaundice" - *Childrens / Digital Nurse* "direct observation of skin integrity" - *Adult Nurse / Nurse Educator*	include any observations about the skin.
	Mobility and Positioning The theme of the patient's ability to change position was brought up in relation to the mobility section, including relocating the elements to the mobility section and removing duplication with the mobility section.	"Frequency of repositioning" - *Adult / Digital Nurse* "No mention of pressure damage (past/present) or frequency of repositioning." - *Tissue Viability Nurse in Paediatrics / Neonatal*	Frequency of repositioning to be considered for adding into the information standard.
	Wound Care Wound care was frequently mentioned, including comments relating to wound care products, treatment plans, and wound history.	"treatment plan for wound care - rather than just the dressing products used." - *Adult / Tissue Viability Nurse* "You've mentioned skin problems as a whole e.g. psoriasis but not specifically wounds. This would be vital for this area and what they are caused from e.g. pressure sores or surgical wounds, and if pressure sores, if they've been Datix'd."	The majority of suggestions are not necessary for an initial assessment, and the PRSB Wound Care Standard can be used to capture this information.

		- *Adult Nurse / CNIO* “Presence of wounds / skin damage. Comprehensive Wound Assessment, including dressing management, type of dressing used and frequency of dressing change.” - *Adult / Digital Nurse*	
	Allergies Several comments had concerns about allergies.	“Allergies to products.” - *Tissue Viability Nurse* “allergies to wound care products would need to be added” - *Adult / Tissue Viability Nurse*	This is captured in the Allergies and Adverse Reactions section of the Core Information Standard.
	Moisture Some comments mentioned moisture affecting skin, particularly in relation to continence.	“Moisture effect on skin - any impact from incontinence or sweating which could impact skin integrity” - *Community Nurse / CNIO* “any moisture related concerns with their skin any incontinence that can impact their skin - the products they use, catheter, moisture from incontinence, sweating due to products,” - *Adult Nurse / Continence Specialist*	Candidate to be added to this section.

	Pain Assessment Pain was also mentioned several times, with some suggesting that pain isn't appropriate to capture here as it can affect things other than skin, and some suggesting more pain options be added.	"In the acute/chronic pain section, maybe include the Abbey pain tool for patients who cannot verbalise their pain" - *Adult Nurse / Clinical Informatics / Deputy CNIO* "Analgesia and acute and chronic pain are important but should probably be grouped with the ability to position. I think that is where it would be most relevant. Wouldn't there be a full pain assessment being carried out anyway?" - *Tissue Viability Nurse* "Pain is not just related to the skin" - *Adult / Tissue Viability Nurse*	Pain is unlikely to be relevant to the skin section and therefore will be removed. However, further consideration of the inclusion of data elements surrounding pain are highlighted as important at initial assessment.
Medication self-management	**Administration method** There were some concerns regarding the granularity of detail necessary for administration method.	"how administered, oral, NG, IV etc Tablet suspension etc" - *Various roles in different organisations* "How do you usually take your medicine - as a tablet/ liquid/ with food/ crushed onto food/ via PEG etc" - *Nurse manager*	The various methods of medication administration will be included in the implementation guidance. However, it is the responsibility local system supplier to ensure they have the appropriate data value sets to ensure documentation of clinical practice is relevant.

	Allergies/ side effects Allergies/ sides effects of medication was highlighted as highly important to capture to ensure the patient/ person does not suffer from inappropriate treatments.	“allergy and sensitivity” - *TVN, Community care* “allergies or reactions/side effects to previous medication preference of medications when unwell e.g. pain relief etc” - *Head of Nursing, Mental health/ learning disability hospital*	This information will be included in the overall Nursing Care Needs Standard after inheriting sections from the CIS.
	Compliance of medication Assessing the person to be compliant with medication was raised as an important assessment to capture to ensure appropriate further action is taken.	“Has the person been taking all the medication prescribed? Are there drugs they no longer take or don't take for some reason? This could prompt education and/or a medication review.” - *Tissue viability* “Is the person compliant with medication regime? If no is there any obvious cause for example education needs? Is the person suffering from side effects?” - *Nurse manager, Acute hospital* “Understanding of why the patient is actually taking the medication and its role in their life/treatment?” - *Digital nurse*	This is highly important; however, if a patient is non-compliant to taking their medication, this should be recorded as a Risk, which is inherited from the CIS.

	Mental Capacity Concerns were raised about the absence of mental capacity assessment in this section.	"Mental capacity act and executive functioning. other diagnosis impact e.g. dementia, LD, autism etc." - *Nurse manager, acute hospital* "capacity to consent to medications and any covert administration plan" - *Mental health nurse*	This information will be included in the overall Nursing Care Needs Standard after inheriting sections from the CIS. E.g., Legal requirements captures Mental Capacity Act. Also, covert administration can be recorded in Medication administration via structured codes or free text, depending on what is available and digital maturity of the organisation.
	Medication information and associated meta data Different nursing settings expressed the importance of medication information and where it would be derived from. However, it was noted that the standard is all encompassing and there should be consideration about mandated items within acute settings.	"In an acute trust usually a pharmacist or pharmacy technician would be responsible for the self-assessment, this isn't something that should be included, if it is then compliance will be minimal as this is another assessment that we are asking nursing staff to complete. Time of last medication administered, this is something that is recorded on our EPMA system. This would be a poor use of nursing time." - *Digital nurse practitioner* "Name and dosage of medicine self administered if known"	There are acute-specific workflows that involve pharmacists that may capture the same information. However, for other settings, the data elements are relevant. Furthermore, some of the information will be captured via EPMA and EPR. The MROs will be consulted with clinicians to ensure acute nurses do not duplicate data recording.

		- *Acute hospital*	
	Storage of medication Comments about the storage of medication were raised.	“storage of medication can be a problem if patients have a large amount of medications our boxes are small” - *Nurse manager, Acute hospital* “Storage of medication for patient use” - *Non-NHS nurse*	The various forms of medication organisation equipment will be included in the implementation guidance.
Further comments/ feedback	**Holistic Approach and Person-Centred Care** Reviewers appreciate the documentation's holistic approach, encompassing multiple facets of a patient's well-being, from hygiene to medication management. This approach is seen as vital for ensuring that all aspects of a patient's needs are considered, promoting person-centred care.	“Could 'person' be used instead of 'patient'? 'A Patient' can indicate an element of control the nurse has over them. People are people, whether they are a patient or inmate!” - *Director/ Assistant Director of Nursing, Nurse care home* “please be consistent with either person or patient if a tool for community person would be more appropriate” - *Senior lecturer, University*	Language and terminology will be updated in the next iteration of the information model.
	Addressing Duplication Concerns	“Perhaps some of the questions could be combined as there are	Further consultation with clinicians and informaticians.

	Concerns are raised about potential duplication if the standard is adopted, leading to additional admission documents and overwhelming workloads for staff. It's suggested that the impact on frontline staff be carefully considered. On a positive note, its adaptability across different healthcare settings, including hospitals, nursing homes, and community care, is acknowledged as a strength.	many of them and time is very precious." - *Practice development nurse, surgery* "some of these questions are repeats and the information could be better obtained with 1 question ." - *CNIO, Community care* "Please consider reducing duplication or removing questions if not appropriate to a patient to avoid unnecessary documentation. Capturing a patient's base line is important." - *CNIO, acute hospital*	
	Consideration of Special Populations The inclusion of provisions for both adults and children within the same documentation is appreciated for its universality. However, it's suggested that specific sections or alternative points for paediatric care be considered, given the unique	"just to avoid repeating information for children or missing items. to include age related information as - is this normal for this baby/ child/ young person" - *Paediatrics*	Language and terminology will be updated in the next iteration of the information model.

	considerations for this population.		
	Digital Integration and Consistency with Standards The potential for digital integration with electronic health records is highlighted as important for tracking, reporting, and data analysis. Aligning with industry standards like PRSB and NMC is seen as essential, but ongoing reviews and updates to match evolving best practices are stressed.	"Digital Health and Care Wales are doing a lot in this area currently at a national level. They have an All Wales Admission document for example." - *Senior clinical consultant (nurse informatics).* "Consider where questions relate to each other, only offering the following options if relevant to the prior question, e.g. problem identified - no then no need to ask a following question. Digital forms can provide this intelligence to avoid over complicated or lengthy documents." - *Digital nurse*	
	Avoiding Complexity Several comments suggest that there are too many questions in the standard, with a preference for simpler overarching questions that trigger further assessment using validated tools. The need to avoid overcomplicating the documentation is emphasized,	"It is very long and repetitive. Feels a bit like a box ticking exercise and I feel staff on the wards will skim over it as there are far too many options in each heading to read." - *Professional Practice Standards and Safety Team-Corporate Nursing*	The MROs will be consulted with clinicians to ensure acute nurses do not duplicate data recording. The purpose of this standard is to capture relevant clinical information, which should then trigger further investigation as the comment suggests.

	with an emphasis on efficiency and user-friendliness.	“Overall, there are too many questions here. Simple, overarching questions should be used which then trigger further enquiry or assessment using a validated tool.” - *Clinical Digital Team (nurses, midwives and AHPs)*	
	Integration Across Professions Some reviewers argue for a more inclusive approach that allows various healthcare professionals to access and contribute to patient assessments within a unified system, reducing the need for redundant data entry by different professions.	“Although I appreciate this is a nursing assessment - I would like to see the AHPs involved with the service users care documented as they will be the experts the staff need to contact.” - *Professional Lead - Learning and Development, Community care*	AHPs are not in the remit of this work.
	Additional Elements for Consideration A range of specific elements are proposed for inclusion in the assessment, such as allergies, nutritional status, cognitive and mental health, communication needs, cultural sensitivity, social and environmental assessment, advanced care planning, physical activity, vaccination	“I thought it was very detailed but was surprised not to see any specific standard about cognition but I may be missing something.” - *Lead nurse older people* “someone's senses will impact on all of these issues: sight, hearing, touch, smell and taste- although touched upon under different headings Also should	The suggested additional elements have been considered in the previous iterations of the standard. However, in consideration of reducing documentation duplication and effort, it was agreed that some information will be captured via the inherited CIS sections, EPR and EPMA, and other local systems. This will be the responsibility of the

	status, family and caregiver involvement, previous medical history, patient education, and review or follow-up plans.	there be something around communication- how best communicate with someone” - *Nurse consultant for a large community trust cover mental and physical health, and health and justice settings*	system supplier to ensure patient information is interoperable.