National Institute for Health and Care Excellence

Pressure Ulcers
Guideline Consultation Table
18/11/13-6/01/14

ID	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
111	SH	Trafford division of Pennine Care NHS Foundation Trust	7	Key priorities for implementation	5.2.37-38	54	What repositioning help would be considered suitable for community patients who are unable to reposition or who's relatives / carers cannot reposition at least every 4 hours (for example over night)? There is no recommendation for dynamic pressure care equipment on the 'elevated risk' prevention algorithm. What about community patients in receipt of care packages which would not allow 'at least 4 hourly' repositioning interventions?	Thank you for your comment. The GDG felt that people who are at risk of developing a pressure ulcer should be repositioned at least every 4 or 6 hours depending upon pressure ulcer risk. The group felt that this was likely to include repositioning through the night. This may impact upon patient acceptability, and care packages but the impact of developing a pressure ulcer was likely to have a greater impact upon quality of life. The GDG acknowledged that the resource implications were likely to be higher in the community, but agreed that the benefits (in terms of financial savings and improved quality of life from prevented pressure ulcers) were likely to be such that repositioning at least every 4 or 6 hours depending on risk status would be cost-effective. The GDG therefore chose to recommend repositioning at least every 4 or 6 hours and individuals should be provided with care packages which allow for this frequency of repositioning. Further detail has been added to the evidence and link to recommendation section. Note that 4

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								hourly repositioning is only recommended for individuals deemed to be at high risk. Due to a lack of evidence, the GDG did not chose to develop a recommendation on the use of dynamic devices for the prevention of pressure ulcers and therefore, a recommendation has not been included in this algorithm.
110	SH	Trafford division of Pennine Care NHS Foundation Trust	6	Key priorities for implementation	5.2.9	52	An individual's pressure ulcer risk factors will only be accounted for if clinicians on initial contact have the skills to recognise the importance of the risk in relation to the individual being assessed. A pressure ulcer risk assessment tool in a valuable aide memoir to clinical decision making at the first patient contact and would trigger a referral on to a service who could generate a preventative care plan where necessary. Therefore especially in primary care settings we should be advocating a documented formal pressure ulcer risk assessment for all patient's on initial contact to establish baseline and allow implementation of a timely prevention strategy.	Thank you for your comment. Recommendations 1.1.1 – 1.1.4 highlight that all individuals receiving NHS care which involves admission to secondary care should be risk assessed on admission and that people who are have a risk factor should be risk assessed when receiving other NHS care. There was insufficient evidence available to the GDG to develop a stronger recommendation for the use of a validated risk assessment tool, so the GDG chose to develop a weaker 'consider' recommendation for the use of these tools. The GDG did however, acknowledge that these tools provide a useful aide memoire for healthcare professionals (see section 7.2.1).
133	SH	APA Parafricta Ltd	6	FULL	General	General	The combination of points 1-5 above, with the input of major organisations such as EPUAP, NPUAP and the papers by Lahmann & Kottner above would suggest that the impact of friction and shear as major extrinsic factors in the development of	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the

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							pressure ulcers should be reviewed before final publication. I request that the Guideline Development Group take this into consideration.	full guideline the potential role of shear and friction to pressure ulcer development.
93	SH	Neurocare Europe Limited	3	FULL	General	General	**Wound Care Canada.2006** Within a series entitled "Best Practice Guidelines", Canadian Health Authorities have published guidance on pressure ulceration. . They note that "there are multiple levels of evidence (of the efficacy of electrotherapy in wound healing) depending on the modality" i.e. the type of electrical stimulation applied. With reference to pressure ulcers the following guideline was made "Use of electrical stimulation therapy (EST) is recommended for treatment of chronic pressure ulcers (level of evidence A)". **Agency for Healthcare Policy and Research USA 1994** In the early 1990's the above agency conducted a comprehensive review which resulted in the publication of a booklet entitled "Pressure Ulcer Treatment" which became and to a large extent has remained the North American standard on the treatment of pressure ulcers. In a section 'Adjunctive Therapies' noting that they have "considered many adjunctive therapies including devices, topical agents and systemic drugs other than antibiotics," they conclude. "At this time, electrotherapy is the only adjunctive therapy with sufficient supporting evidence to warrant recommendation by the panel. The panel recommends that clinicians consider a course of	Thank you for your comment. The guideline considered pressure ulcers only and therefore, the GDG chose to exclude studies of other wounds. The GDG also chose to include only randomised controlled trials, where these were available, as the highest level of evidence. The NPUAP recommendation to which you refer was based on 3 RCTs (which were also included in NICE guideline) and a meta-analysis. The meta-analysis (Garder et al, 1999) included wounds other than pressure ulcers and included a variety of study designs. They also refer to a Cochrane reviews of electromagnetic therapy, which was excluded from the current guideline. The studies found in the current review were very small and showed no clinical benefit for the complete healing of pressure ulcers. For many outcomes, there was also evidence of substantial skew in the data, although despite this log transformations had not been carried out (compromising accurate interpretation of 95% CIs). The evidence was downgraded accordingly, resulting in a GRADE rating of low to very low overall. The

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							treatment with electrical stimulation for stage III and 1V pressure ulcers. Electrical stimulation may also be useful for recalcitrant stage II ulcers". In arriving at this conclusion the Agency cites 10 clinical studies (AHCPR, Pressure Ulcer Treatment 1994) some of which are also included in the present NICE document. In the year 2000 the Consortium for Spinal Cord Medicine (USA) concluded that in treating pressure ulceration electrotherapy was supported by the highest level of evidence followed in 2006 by The Wound Healing Society (USA) who independently reached the same conclusion. The established practice in the USA now, followed by Medicare, Medicaid and all the Private Health Insurers is that a course of electrotherapy is indicated after one month of conventional therapy has not achieved or progressed toward a cure. **EPUAP/NPUAP Published 2009** This was a comprehensive collaborative piece of work which had, as participants, many eminent specialists from Europe and North America in the field of wound care, many being specialists in pressure ulceration. Over a period of around four years this group considered all aspects of the classification, prevention and treatment of pressure ulcers. In recommendations for treatment the only 'A' level recommendation made was "Consider the use of direct contact (capacitative) electrical stimulation (ES) in the management of recalcitrant Category/Stages II, III and 1V pressure ulcers to facilitate wound healing."	GDG also thought that electrotherapy was possibly likely to be of greater benefit for grade 3 and 4 pressure ulcers and therefore we analysed this data separately but found no clinical benefit for electrotherapy over placebo. The comment on page 253 of the full guideline to which you refer is based upon the qualitative responses gathered from members of the Delphi consensus panel, rather than the Guideline Development Group, as you state.

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							<u>Cochrane Collaboration protocol</u> Results of trials under consideration within the Cochrane protocol "Electrical stimulation for chronic wounds." Cochrane are considering 22 trials including 10 of the 14 in the current NICE document. We would stress that these results have been presented by the authors only as conference papers and and may not appear in the form reproduced here in a Cochrane Review The primary measure of effect chosen was percentage area reduction of the ulcer after four weeks treatment (PAR4). Eighteen of twenty studies reported a significant improvement in healing outcomes in electrically stimulated (ES) treated wounds compared with control wounds. With pressure ulcers PAR4 was 25% better than control and with ulcers of all etiologies (i.e. the whole sample) PAR4 was 32.5% better. Risk Ratio (RR) analysis of complete healing of pressure ulcers , showed an improved probability of healing of 2.61 (i.e. the chances of healing with electrical stimulation increased by 261%.) With the trials conducted with TENS devices removed from the analysis the RR increased to 5.76. The Authors conclude that "ES stimulates faster wound size reduction in all types of chronic wounds" and that "the report provides the highest level of evidence to support the clinical use of ES for the treatment of chronic wounds,"	

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							.Meta Analysis Effect of electrical stimulation on chronic wound healing (Gardner SE et al 1999) This meta-analysis in its introduction reported "most clinical trials of ES found that it is an effective adjunctive therapy for healing chronic wounds" and "Nonetheless attention to differences among ES devices has caused many to ignore this body of evidence". "Rate of healing per week was 22% for electrical stimulation samples and 9% for control samples and "an increase of 144% over the control rate." This meta-analysis which took place in 1999 includes some of the studies which NICE are considering in this current work **Review Article-Electrical stimulation to accelerate Wound Healing (Diabetic foot and ankle 2013.Gaurav Thakral et al)** This review was undertaken primarily to assess whether electrotherapy could serve as an effective adjunct to plastic surgery and analysed 21 RCTs, subsequently reduced to 16,10 of which were also included in the Cochrane study. No attempt was made to aggregate the results but with the trial results tabulated it was concluded that "Despite variations in the type of current, duration, and dosing of electrical stimulation, the majority of trials showed a significant improvement in wound area reduction or wound healing compared to the standard of care or sham therapy....."	

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							Whilst acknowledging several limitations in their review, their conclusions are unusually unequivocal including such statements as "In many ways electrical stimulation appears to be a perfect adjunctive therapy." And...." First, no device related complications or adverse effects have been reported in the existing literature. The therapy is safe and easy to use Second, as electrical stimulation decreases bacterial infection, increases local perfusion and accelerates wound healing, it addresses these three pivotal factors in surgical wound complications" and later "Electrical stimulation offers a unique treatment option to heal complicated and recalcitrant wounds....." NICE Review 2013/4 We do not seek (nor indeed are able) to judge the relative competence and experience of the above Bodies in relation to robustness of process and technical quality of conclusions reached in comparison with your own. Nor would we challenge your freedom to adopt whatever procedures or clinical trial selection criteria you consider appropriate. We would however make the following points: Electrotherapy is widely used in North America in many applications, wound healing being but one. There is a substantial and growing evidence base. In contrast knowledge and experience in the UK is minimal and in the wound healing application virtually nil. We would venture to suggest that Guideline Development Group members are unlikely to have had personal clinical experience of	

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							the therapy and indeed it is noted on page 253 of the main document that "Comments received from panel members highlighted that they were unaware of evidence to support the use of electrotherapy". The Canadian and American authorities cited above are substantial and experienced government bodies Their conclusions and recommendations merit proper weight in any appraisal of clinical practice and consideration of clinical evidence in the field. EPUAP/NPUAP was one of the single most significant European/North American collaborations yet established to consider best clinical practice and clinical evidence in healthcare. In studying all aspects of pressure ulceration their overall approach was broadly similar to that subsequently adopted by NICE. Their conclusions were comprehensively researched and unequivocal. Electrotherapy was the only adjunct therapy with sufficient strength of RCT evidence(level1) to support a recommendation for adoption as a treatment modality for all stages of pressure ulceration . The Cochrane Collaboration work in this area is not yet concluded and it is not our intention to anticipate the content of whatever final report is published.We note however that the evidence which the Cochrane Researchers have published/presented to date has shown significant improvement in healing outcomes with pressure and other forms of ulceration using various types of electrotherapy compared with standard therapy. In most of the	

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							clinical trials under consideration percentage ulcer area reduction in four weeks was 25% faster than that achieved by standard treatment. In summary we believe that your current work, whilst comprehensive, risks being diminished by significant omissions. We confine this criticism to those sections of the report which we as manufacturers of electrotherapy devices are most familiar with. But whilst the conclusions of several other eminent bodies on the subject of electrotherapy and pressure ulcer treatment are neither referenced nor acknowledged anywhere within this work it risks being judged as flawed and incomplete.	
10	SH	Royal College of Paediatrics and Child Health	1	FULL	General	General	We feel this is a useful guideline and applicable to children and young people with disability (as well as to those without). We have no specific other suggestions to offer.	Thank you for your comment.
167	SH	The James Cook University Hospital, The Golden Jubilee Regional Spinal Cord Injury Centre	1	FULL	General	General	There is no mention of special needs of spinal cord injured patients. This group represents an extremely vulnerable group in which pressure ulcers are common. It is extremely disappointing to note that no reference is made at all to this highly vulnerable patient group.	Thank you for your comment. The needs of people with spinal injuries were considered throughout development of the guideline. For relevant review questions, people with a spinal injury where included asa strata in the review protocol (see Appendix C). This evidence was considered by the GDG but there was no evidence identified to support the notion of different preventative strategies or management considerations. People with a spinal cord injury were

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								considered to be at high risk of developing a pressure ulcer and therefore, recommendations developed for this group would be applicable to these individuals. The Guideline Development Group included two patient/carer members. They were involved in developing all guideline recommendations.
171	SH	The James Cook University Hospital, The Golden Jubilee Regional Spinal Cord Injury Centre	5	FULL	General	General	It is commented that no mention is made of the contribution of shear in the generation of pressure ulcers. In the commonly observed position of 45 degrees angulation in bed, to the injury of pressure the insult of shear is added. It is important that when a spinal cord injured patient is seated they are seated upright.	Thank you for your comment. We have highlighted the role of friction and shear in the guideline introduction. We have not looked at the evidence for seating position specifically for spinal cord injured patients as the GDG did not prioritise this topic as they did not consider there would be any specific management considerations for this group and therefore we are unable to make a recommendation on this.
223	SH	Tissue Viability Society	19	FULL	General	General	We were unable to find the definition of the term 'pressure ulcer' or an explanation of the classification systems used	Thank you for your comment. A definition of the term pressure ulcer is provided in the glossary of the full guideline. A glossary of all instruments used for categorising pressure ulcers is provided in Table 12 of the full guideline on pressure ulcer management
112	SH	Trafford division of Pennine Care NHS Foundation	8	FULL	General	General	What is the preventative guidance on the provision of non wheelchair seating equipment?	Thank you for your comment. The GDG agree and recommendation 1.1.17 has been revised to highlight

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		Trust						that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered.
114	SH	Trafford division of Pennine Care NHS Foundation Trust	10	FULL management of PU	General	General	Seems very acute focused with little practical advice regarding repositioning times and seating equipment for community environments	Thank you for your comment. The recommendations within the guideline apply to all NHS settings. However, the GDG agree that there are limited recommendations on the use of seating and recommendation 1.1.17 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community.but feel that provision should be put in place to allow this to be implemented. Recommendation 1.1.8 and 1.1.9 are also applicable to community environments as the benefit of preventing pressure ulcers would be of impact to quality of life.
145	SH	APA Parafricta Ltd	18	FULL	General	General	We ask NICE consider and/or recommend systems of audit and performance management to be used for pressure ulcer prevention.	Thank you for your comment. An audit tool will be developed by NICE to support implementation of the guideline.
11	SH	Birmingham	1	FULL	General	Ge	Disappointed to note there is no reference to	Thank you for your comment. We

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		Community Healthcare Trust				neral	potential neglect as a significant factor in the cause of pressure ulcers. Many Safeguarding Boards have included proformas for pressure ulcers – i.e. is neglect a contributing factor?	hope that publication of the guideline will ensure good quality care that prevents pressure ulcers due to neglect. We have included a statement on page 5 of the NICE guideline acknowledging the importance of safeguarding in children.
12	SH	Birmingham Community Healthcare Trust	2	FULL	General	General	There is only a brief reference to the Mental Capacity Act in the NICE draft. It my have been opportune to expand on this information as practitioners are increasingly finding this an important consideration in the management of pressure ulcers and also that practitioners will need to make a Best Interest Decision if the patient lacks mental capacity for that specific decision.	Thank you for your comment. Recommendation 1.3.2 highlights that the additional needs of people with cognitive impairment should be considered when supplying information on pressure ulcer prevention.
13	SH	Birmingham Community Healthcare Trust	3	FULL	General	General	Patient non-compliance (for patients with mental capacity) for pressure ulcer dressings and equipment are a significant challenge for practitioners, again it may have been useful to have some guidance here.	Thank you for your comment. We did consider patient concordance within the outcome 'acceptability of treatment' on the review on the clinical and cost effectiveness of dressings and pressure redistributing devices. This is reflected in recommendation X which highlights that pain and tolerability should be considered when choosing an appropriate dressing. However, people with cognitive impairment were not considered as a separate subgroup for these questions and therefore, we did not chose to make a specific recommendation for this population. Recommendation 1.3.3 also highlights

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								that the individual needs of people with cognitive impairment should be considered when supplying information to patients and their carers.
14	SH	Birmingham Community Healthcare Trust	4	FULL	General	General	The difficulties experienced in pressure ulcer management now for clinicians is the parts that are outside of the scope, i.e. device related ulcers, diabetic foot ulcer or pressure ulcer, ischaemia or pressure related skin damage. This aside, there is very little change from the original guidance. I do not agree with 4 hourly repositioning as suggested and whilst I accept there is no evidence for 2 hourly, there most certainly is not for 4 hourly either. This would place vulnerable patients at higher risk of developing pressure damage than they currently are. There is not enough regarding safeguarding. If a pressure ulcer occurs and is proven through RCA to be avoidable. Should this be a safeguarding as there has been clinical neglect of the patient causing harm. This would require discussion but I would like to raise for consideration.	Thank you for your comment. As you note, these areas were outside the scope of the guideline. Recommendations on the management of diabetic foot ulcers are included in NICE clinical guideline 119 'Diabetic foot problems – inpatient members' and NICE clinical guideline 10 'Type 2 diabetes – footcare'. We have included details on the importance of acknowledging safeguarding on page 5 of the NICE version of the guideline. The GDG felt that people who are at risk of developing a pressure ulcer should be repositioned at least every 4 or 6 hours depending upon pressure ulcer risk. This is based on GDG expert consensus, informed by an economic analysis which showed that alternate 2 and 4 hourly repositioning was not cost-effective compared to 4 hourly repositioning.
104	SH	Department of Health	1	FULL	General	General	Thank you for the opportunity to comment on the draft for the above clinical guideline. I wish to confirm that the Department of Health has	Thank you for your comment.

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							no substantive comments to make, regarding this consultation.	
69	SH	Guys and St Thomas NHS Foundation Trust	13	FULL	General	General	Although 'shear' in mentioned 18 times in the document, it fails to accept the importance of shear (as opposed to 'pressure') in the causation and management of 'pressure' ulcers. My personal experience at a doctor with a C4/5 incomplete tetraparesis indicates that 'shear' was more important than 'pressure' in the causation of ulcers that developed on my feet from 'friction' in my bed during regular 8 - 10 hour periods of bed-rest at night. After the ulcers developed I immediately took steps to reduce the pressure on the relevant 'pressure' points involved. None of the many methods of pressure reduction that I tried worked. It was only after reading about the effectiveness of Parafricta in patients with epidermolysis bullosa that I tried this method of reducing friction and within days my ulcers began to heal. The method I used initially was Parafricta in the form of bootees. It was soon apparent that at least in my case, reducing shear was more important than reducing pressure. The ulcers healed rapidly and by using a Parafricta 'draw sheet' under my feet at night I have had no further trouble over five years. My case study has been published in the BMJ and below are photographs taken before the use of Parafricta in 2008 and the present state of the same area 5 years later. There have been no further problems since using a Parafricta draw sheet. I believe that more emphasis should be given to the equal importance of pressure and shear (that is of course also greatest on 'pressure points') in	Thank you for your comment. Following discussion on the topics to be included, the GDG decided to conduct a review on methods of risk assessment rather than looking at the additional causative factors of pressure ulcers, as the GDG felt that there was a large number of risk assessment tools available for healthcare professionals and that this would be the most helpful area in which to provide recommendations. . A review was conducted for pressure redistributing devices but the GDG did not prioritise devices to reduce shear and friction. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development. A NICE Technology appraisal is currently under development on the effectiveness of Parafricta and this has been highlighted in section 3.2 of the NICE guideline.

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							causation of ulcers and that reducing shear using techniques such as the use of Parafricta are of equal importance to reducing pressure in both prevention and therapy of 'pressure' ulcers. Since Parafricta is the ONLY method of reducing shear it would in my opinion be negligent not to include this even though RCT data may be limited.	
91	SH	Neurocare Europe Limited	1	FULL	General	General	This document does not consider the preventive role which neuromuscular electronic stimulation (NMES) can play in improving muscle bulk and condition around sites vulnerable to pressure ulceration. By replicating exercise atrophy can be reversed and local perfusion greatly enhanced. Muscle tissue brought into better condition is more resilient and will distribute and cushion body weight over a broader area thus avoiding the concentration of weight on promontories which are usually the point at which ulceration starts.Clinical studies in this application have been concluded with very positive results Adoption of this technology which is well tolerated and inexpensive would bring improvement in patient benefit and significant treatment cost reduction by avoiding the incidence of pressure ulceration. This may serve to avoid or defend the increasingly common incidence of litigation alleging negligent care since the hospital would be able to show best avoidance practice. It must always be preferable to adopt therapies that will improve the patient condition in this instance by improving tissue condition to avoid deterioration and ulceration than to attempt to compensate for and accommodate its progressive deterioration.	Thank you for your comment. Neither the stakeholders nor the GDG prioritised neuromuscular electronic stimulation as a preventative device but instead prioritised electrical stimulation for the treatment of pressure ulcers.
35	SH	Newcastle upon	1	FULL	General	Ge	I would recommend that you separate the adult	Thank you for your comment. The

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		Tyne Hospitals NHS Foundation Trust				neral	recommendations to the paed/neonate ones – this becomes easier to read.	recommendations for neonates, children and young people have been separated within the NICE guideline and full guideline chapters.
127	SH	NHS England	1	FULL	General	General	Thank you for the opportunity to comment on the draft scope of the above clinical guideline. I wish to confirm that NHS England has no substantive comments to make regarding this consultation	Thank you for your comment.
183	SH	Royal College of Nursing	1	FULL	General	General	The Royal College of Nursing welcomes proposals to update this guideline.	Thank you for your comment.
181	SH	Royal College of Physicians	1	FULL	General	General	The Royal College of Physicians wishes to endorse the response submitted by the British Association of Dermatologists to the above consultation.	Thank you for your comment.
146	SH	Royal Pharmaceutical Society	1	FULL	General	Genral	The Royal Pharmaceutical Society, the professional body for pharmacists and pharmacy in Great Britain, welcomes new NICE clinical guidance on pressure ulcers and generally support the recommendations.	Thank you for your comment.
185	SH	Royal College of Nursing	3	FULL	Introduction	12	Line 2: ...*often represent a failure of care* - Would prefer the word 'can' or 'may' rather than *often* which implies that most pressure ulcers are caused in this way which is not always the case.	Thank you for your comment. This has been amended.
186	SH	Royal College of Nursing	4	FULL	Introduction	12	Line 32: *prevention received fully adequate preventive care*. In reality this was those who had preventative care adequately documented.	Thank you for your comment. We believe that this is clear and no amendment has been made.
218	SH	Tissue Viability Society	14	FULL prevention	General	General	Use of the term 'offer' and 'encourage' Many of the guideline recommendations use the word 'offer' and 'encourage'. In the pressure ulcer prevention field there is currently a blame culture. Managers blame	Thank you for your comment. As outlined on page 6 of the NICE guideline, the GDG choose to develop 'offer' recommendations when they are confident that, for the vast majority of patients, an intervention will do

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							nurses, nurses blame patients – 'well he refused to be turned'. In a recent study exploring organisational factors associated with severe PU development, it was noted that in situations where patients or carers refused care options, that nurses then absolved themselves of all further responsibility. They did not escalate the management problems they had in caring for difficult and clinically complex patients. http://bmjopen.bmj.com/cgi/content/full/bmjopen-2013-004303 Using the term 'offer' in the context of nursing care delivery will allow the majority of pressure ulcers to be classified as 'unavoidable' and practice standards to fall, particularly for high risk vulnerable patients (for example those who are confused/lack capacity).	more good than harm. The use of this term reflects the importance of acknowledging patient choice when providing an intervention.
184	SH	Royal College of Nursing	2	FULL prevention	General	General	Exclusions: Device related and end of life. It would be helpful, in current climate, to include rationale behind this exclusion. For instance the usual pathways and tools of risk assessment and prevention are not relevant to these groups of pressure damage.	Thank you for your comment. Device related pressure ulcers and end of life care were excluded from the guideline during the scoping phase as they were considered to have specific prevention and management strategies that are beyond the scope of the guideline.
79	SH	Leonard Cheshire disability	1	FULL prevention	general	general	At first glance this is an extremely large document which is very off-putting	Thank you for your comment. The size of the guideline reflects the breadth of review questions conducted.
205	SH	Tissue Viability Society	1	FULL prevention	General	General	The Tissue Viability Society must first congratulate the review team on the robust review and appraisal process used to develop	Thank you for your comment.

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							this important guideline	
206	SH	Tissue Viability Society	2	FULL prevention	General	General	Whilst recognising that a robust appraisal method is required for National guidelines, it is unfortunate that the GRADE appraisal system does not allow any distinction between large multi-centred fully powered publicly funded trials with limitations and very small underpowered trials with high risk of Type 1 and 2 errors.	Thank you for your comment. The GRADE appraisal system takes into account all risk of bias in a study. A fully powered trial will be more likely to show narrow confidence intervals and therefore results will be less likely to be downgraded on imprecision. However if there is other risk of bias in the study then they will be downgraded accordingly.
211	SH	Tissue Viability Society	7	FULL prevention	General and Section 3.3.1.7	37	Risk assessment tools. The guideline team are congratulated on their comprehensive review of this area of the literature. Such a review has not been undertaken previously to the same standard and presentation of results are in an accessible format. However, the guideline statements refers to 'validated' risk assessment tools, but there is no definition of 'validated'. Assessment of the validity of an instrument should include appraisal of the development method, conceptual framework, reliability, content, construct and known groups validity as well as prospective 'testing' of predictive validity. The appraisal criteria described on page 37 includes only appraisal criteria for prospective testing of published instruments and does not consider that none of the instruments were developed using 'gold standard' methods. The recommended 'validated' risk assessment tools are really those that have been subject to	Thank you for your comment. The definition of risk assessment tools have been expanded to refer to validation.

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							prospective testing.	
67	SH	Guys and St Thomas NHS Foundation Trust	11	appendices	General		When to refer for specialist intervention What about darker / coloured skin? Include declining to be documented for all patients of all ages Consent for treatments and intervention	Thank you for your comment. Recommendation 1.1.5 has been amended to clarify that non-blanchable erythema may present as discolouration or skin colour changes in pigmented skin. We have also highlighted this issue on the 'Equality Impact Assessment' form, which is available on the NICE website. It is assumed that consent will be sought and the use of the word 'offer' in recommendation 1.1.5 reflects this.
62	SH	Guys and St Thomas NHS Foundation Trust	5	appendices	1.1.1		Should this include those in there homes with district nurse input or with carers	Thank you for your comment. As outlined in section 2.3, the guideline is applicable to all healthcare settings in which NHS care is provided. This may include the person's home.
58	SH	Guys and St Thomas NHS Foundation Trust	1	appendices	1.1.2		Include vascular insufficiency	Thank you for your comment. The list of risk factors outlined in recommendation 1.1.2 are provided as examples only and are not intended to be exhaustive. A footnote has been included to clarify this.
63	SH	Guys and St Thomas NHS Foundation Trust	6	appendices	1.1.3		Consider change in mental state	Thank you for your comment. The list of clinical scenarios in which a pressure ulcer risk reassessment is required are provided as examples only and are not intended to be exhaustive.
64	SH	Guys and St Thomas NHS Foundation Trust	7	appendices	1.2.2		Consider including where there are devices inserted such as IV lines etc	Thank you for your comment. However, we do not agree that this is a relevant component of skin assessment and pressure ulcers

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								caused by devices were excluded from the scope of this guideline.
65	SH	Guys and St Thomas NHS Foundation Trust	8	appendices	1.2.21		Moisture lesion or incontinence associated dermatitis	Thank you for your comment. This has been amended.
66	SH	Guys and St Thomas NHS Foundation Trust	9	appendices	1.4.11		TNP will speed healing I high risk patients who's are at risk of infection or have infection present	Thank you for your comment. Chapter 7.1 reviews the evidence on negative pressure wound therapy for the management of pressure ulcers. Limited evidence was identified considering the use of negative pressure wound therapy on pressure ulcers. Two studies showed no benefit of negative pressure wound therapy compared with gel dressings or gauze dressing. One study should some benefit of negative pressure wound therapy compared to standard treatment on complete healing. However, there was an increase in pain and mortality in the negative pressure wound therapy group. The GDG therefore chosen not to recommend negative pressure wound therapy for the management of pressure ulcers.
68	SH	Guys and St Thomas NHS Foundation Trust	12	appendices	1.4.13		All staff undertaking sharp debridement should be suitably qualified	Thank you for your comment. We agree and this is highlighted in the 'Linking evidence to recommendations' table in section 8.4.1 of the full guideline.
66	SH	Guys and St Thomas NHS	10	appendices	1.4.20		Unless clinically indicated eg:critical colonisation	Thank you for your comment. The GDG considered the trade off

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		Foundation Trust						between clinical benefits and harms of using topical antimicrobials and antiseptics for the treatment of pressure ulcers. As outlined in the 'Linking evidence to recommendations' section (see 10.2.1), the GDG acknowledged that there may be specific situations in which these may be used however, they should not be used routinely.
61	SH	Guys and St Thomas NHS Foundation Trust	4	appendices	1.3.4		Include grading of pressure ulcers	Thank you for your comment. Recommendation 1.3.4 outlines the necessary training for healthcare professionals who have contact with people at high risk of developing a pressure ulcer and therefore, we do not agree that it is appropriate for this recommendation to include pressure ulcer grading.
59	SH	Guys and St Thomas NHS Foundation Trust	2	appendices	1.1.8		Prevention intervention strategies	Thank you for your comment. The list of factors outlined in recommendation 1.1.8 are provided as examples only and are not intended to be exhaustive.
60	SH	Guys and St Thomas NHS Foundation Trust	3	appendices	1.1.9		At risk depending on the skin assessment	Thank you for your comment. Adults who have been assessed as being at risk would be identified via a risk assessment (see recommendation1.1.2 and 1.1.3).
22	SH	Swansea Centre for Health Economics, Swansea University	1	Appendix L	L.1	General	The difference in incidence of pressure ulcers between the studied intervention group reported by Vanderwee et al. (2007) was not statistically significant (P = 0.40). The severity (P = 0.65) and location (P = 0.19) of pressure ulcer lesions, and the time to developing them (P = 0.29) were also similar in both groups.	Thank you for your comment. Statistical significance is not required for economic evaluation, and the GDG wished to assess the relative cost-effectiveness of these strategies. The analysis was useful to inform the recommendations.

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							It cannot therefore be concluded that more frequent repositioning is a more effective preventive measure. If you cannot conclude that either intervention is more clinically effective than the other, can you usefully evaluate cost effectiveness?	
25	SH	Swansea Centre for Health Economics, Swansea University	4	Appendix L	L.1.3	9-10	The point estimate chosen for utility loss from pressure ulcer is 0.026; a value slightly below that estimated in the literature (0.028 – with no distinction between grades of severity). Justification for the choice of 0.026 is not given in the report; though a comment in the model file indicates that a lower value was chosen to reflect the inclusion of grade 1 pressure ulcers. The trial included ulcers of grade 2-4 only. How does the severity profile seen in the Soares study compare to the trial and to that implemented in the model? Though the choice of the point estimate 0.026 could be considered a conservative assumption of disutility, which was shown to have little influence on the results through sensitivity analysis, it would be useful to fully explain the discrepancy between literature and chosen input.	Thank you for your comment. The value of 0.026 was taken from the Soares study; justification for choice of this value is provided in section L1.3.3.
27	SH	Swansea Centre for Health Economics, Swansea University	6	Appendix L	L.2.2	15	Citation should be Table 8	Thank you for your comment. This has been amended.

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28	SH	Swansea Centre for Health Economics, Swansea University	7	Appendix L	L.2.2	15	It is stated that sensitivity analyses showed results to be robust to changes in "key assumptions, costs, and frequency of dressing change". Frequency of dressing change was not subject to sensitivity analyses (rather it is the difference between the interventions compared).	Thank you for your comment. This was an error and has been removed.
33	SH	Swansea Centre for Health Economics, Swansea University	12	Appendix L	L.3.10	26	Though availability of evidence does not allow modelling of any difference in time to healing (which may not indeed exist), should the limitations of assumed equal length of treatment and a 2-week horizon be noted?	Thank you for your comment. This has been noted as a limitation in the relevant section.
24	SH	Swansea Centre for Health Economics, Swansea University	3	Appendix L	L.1.3.1	9-11	The average cost of pressure ulcers was calculated to reflect the average in the UK, rather than those specifically developed in the trials. As measured outcomes of the trial, it seems intuitive that both frequency and severity of ulcer are important outcomes of comparative interventions. How did the severity of pressure ulcers developed in the trials compare to those developed in the UK? Could differences between the two severity profiles lead to differences in the results of modelling and was this tested in sensitivity analysis?	Thank you for your comment. If changed to reflect the distribution of pressure ulcers as reported in the trial, the cost of treating a pressure ulcer increases to approximately £6,200. SA4 (see Appendix L page 13) shows that ceteris paribus the cost of a pressure ulcer would have to increase to £16,734 in order for intervention 2 to be cost-effective compared to intervention 1, therefore we can infer that the model would be robust to this change. Note that only the costs are influenced, as quality of life is not linked to pressure ulcer severity in this model.
23	SH	Swansea Centre for Health Economics, Swansea University	2	Appendix L	L.1.2.2	9	Why were the variables (1) resource use and (2) cost of treating a pressure ulcer not included in the PSA? (1) While the cost of staff time may be assumed to be fixed according to national pay scales, there is	Thank you for your comment. This is an area of methodological debate, and it was judged that incorporating these variables probabilistically would not aid interpretation of the results. These variables were explored in

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							uncertainty around the number of staff and time required to reposition a patient. This has been acknowledged through the performance of univariate sensitivity analysis around these variables. These sensitivity analyses showed that changes to these parameter values were influential to the ICER, though not the conclusion of cost effectiveness. (2) Similarly the existence of uncertainty around the cost of treating a pressure ulcer has been acknowledged by the performance of threshold analysis around this variable. While there may not have been an error estimate available, some assumption could have been made regarding the feasible amount of uncertainty around the input value used – perhaps informed by the GDG's opinion of possible costs of treating pressure ulcers. Excluding this variable from the PSA could be viewed as equivalent to assuming the error estimate is equal to zero.	deterministic sensitivity analyses.
26	SH	Swansea Centre for Health Economics, Swansea University	5	Appendix L	L.1.5	12	Would multivariate sensitivity analyses combining change in time and staff required for each repositioning also be informative? Could the number of staff influence the time required to conduct a repositioning procedure?	Thank you for your comment. The GDG did not feel that 5 minutes was a realistic time to complete repositioning, and did not wish to explore this sensitivity analysis any further.
34	SH	Swansea Centre for Health Economics, Swansea University	13	Appendix L	L.3.10.2	27	How likely is it that a pump's lifetime would be long enough to equate to a daily cost of £4 (£1)?	Thank you for your comment. The GDG were not able to estimate the lifetime of a pump, therefore this information is not available.
29	SH	Swansea Centre	8	Appendix L	L.3.4	19	Information relating to frequency of dressing	Thank you for your comment. Neither

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		for Health Economics, Swansea University					changes and time required was not extracted from clinical papers; instead GDG opinion was used. Was any evidence that was available from clinical papers used to inform sensitivity analysis around the inputs estimated by the GDG?	of these variables were reported in the clinical reviews, and are likely to be influenced by trial protocols when taken from clinical studies. The GDG wished to use GDG opinion to estimate these values to ensure they were representative of clinical practice in the UK NHS.
30	SH	Swansea Centre for Health Economics, Swansea University	9	Appendix L	L.3.4	19	Why was the lower cost of time for Band 7 chosen? Is supervision of a Band 5 nurse's patient contact very different to patient contact?	Thank you for your comment. Neither of these variables were reported in the clinical reviews, and are likely to be influenced by trial protocols when taken from clinical studies. The GDG wished to use GDG opinion to estimate these values to ensure they were representative of clinical practice in the UK NHS.
31	SH	Swansea Centre for Health Economics, Swansea University	10	Appendix L	L.3.4	22	Did GDG members only provide one set of local costs? If costs from various NHS Trusts were provided, are the costs reported the average of these costs and were the range of costs tested in sensitivity analyses?	Thank you for your comment. Only one set of local costs were obtained.
32	SH	Swansea Centre for Health Economics, Swansea University	11	Appendix L	L.3.9	23-25	Some issues with replication of tables in place of their citations.	Thank you for your comment. This has now been amended.
109	SH	Trafford division of Pennine Care NHS Foundation Trust	5	Elevated risk Pressure redistributing devices	algorithm B	50	Not all those at elevated risk use a wheelchair. What about specialist chair cushions for those with limited ability to reposition while seated in a chair.	Thank you for your comment. The GDG agree and recommendation 1.1.16 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods

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								of time should be considered.
108	SH	Trafford division of Pennine Care NHS Foundation Trust	4	Elevated risk repositioning	algorithm B	50	What repositioning help would be considered suitable for community patients who are unable to reposition or who's relatives / carers cannot reposition at least every 4 hours (for example over night)? There is no recommendation for dynamic pressure care equipment on the 'elevated risk' prevention algorithm. What about community patients in receipt of care packages which would not allow 'at least 4 hourly' repositioning interventions?	Thank you for your comment. The GDG felt that people who are at risk of developing a pressure ulcer should be repositioned at least every 4 or 6 hours depending upon pressure ulcer risk. The group felt that this was likely to include repositioning through the night and that, although this was likely to impact upon patient acceptability, the impact of pressure ulcer development was likely to have a greater impact upon quality of life. The GDG therefore chose to recommend repositioning at least every 4 or 6 hours and individuals should be provided with care packages which allow for this frequency of repositioning. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.
107	SH	Trafford division of Pennine Care NHS Foundation Trust	3	Elevated risk Skin assessment	algorithm B	50	2 hourly skin palpation would not be achievable in community settings.	Thank you for your comment. However, the GDG felt that an individual with non-blanchable erythema should receive regular skin assessment in all settings to ensure that pressure ulcer development is prevented. However, we have amended the recommendation to highlight the importance of initiating

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								appropriate preventative action in adults who have non-blanching erythema and that in these individuals, healthcare professionals should consider repeating the skin assessment at least every 2 hours until resolved. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.
142	SH	APA Parafricta Ltd	15	FULL		9	We ask you consider recommending training on what pressure ulcers are and how they form. We ask you consider specific consideration of evidence-based friction and shear reduction for heel PU prevention and management of stage I +/- II. We ask you consider specific consideration of evidence-based friction and shear reduction for sacral PU prevention and management of stage I +/- II.	Thank you for your comment. Recommendations 1.3.4. and 1.3.5 provides an outline of elements which should be included in training for all healthcare professionals and includes details of how to identify pressure damage. It is outside the scope of the current guideline to develop specific training on different pressure ulcer sites and grades.
113	SH	Trafford division of Pennine Care NHS Foundation Trust	9	FULL	Algorithm D	10	Need information regarding seating requirements on the algorithm.	Thank you for your comment. The GDG agree and recommendation 1.1.16 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered. The algorithm has been amended to reflect this recommendation.
105	SH	Trafford division of Pennine Care	1	FULL	algorithm B	50	What about cushion provision for individuals at risk of pressure ulceration whilst seated?	Thank you for your comment. The GDG agree and recommendation

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		NHS Foundation Trust						1.1.16 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered.
106	SH	Trafford division of Pennine Care NHS Foundation Trust	2	FULL	algorithm B	50	What about overnight periods which may exceed 6 hours? What about those in receipt of care packages that do not include overnight provision?	Thank you for your comment. The GDG felt that people who are at risk of developing a pressure ulcer should be repositioned at least every 6 hours. The group felt that this was likely to include repositioning through the night and that, although this was likely to impact upon patient acceptability, the impact of pressure ulcer development was likely to have a greater impact upon quality of life. The GDG therefore chose to recommend repositioning at least every 6 hours. Further details of the discussion relating to the trade off between benefits and harms can be found in section 9.3.1 in the full guideline. As outlined in recommendation 1.3.1, an individualised care plan should be developed for all adults at high risk of developing a pressure ulcer and individuals should be provided with care packages which allow for this frequency of repositioning. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision

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								should be put in place to allow this to be implemented.
80	SH	Leonard Cheshire disability	2	FULL prevention	1	12, line 43/ 44	Does the guidance apply in full to social care settings (I don't see why it shouldn't)? If the guidance applies to all people funded by NHS this then applies to some people receiving care in care homes with nursing – can this then be generalised to all care homes with and without nursing care? If this document is to apply to social care there are a number of references to 'healthcare professionals' throughout the document which would need to be amended to read 'health and social care'	Thank you for your comment. As you correctly state, the guideline is applicable to all settings in which NHS care is commissioned or provided however, non-NHS settings, including social care, may choose to adopt the guidance.
143	SH	APA Parafricta Ltd	16	FULL	1	10	We recommend support of a definition of a standardised (Braden) assessment framework where needed in risk assessment, and guidelines on selecting which one to use.	Thank you for your comment. Insufficient evidence was identified to recommend the use of a validated risk assessment tool for all patients. However, the GDG acknowledged that there were some benefits to using a validated risk assessment tool and therefore chose to develop recommendation 1.1.3 to consider using these tools. Further detail on how this recommendation was developed can be found in the 'Linking evidence to recommendation' section 7.2.1.
132	SH	APA Parafricta Ltd	5	FULL	1	10	line 3 to 6The NPUAP White Paper on Friction [December 31 2012] http://www.npuap.org/wp-content/uploads/2012/01/NPUAP-Friction-White-Paper.pdf also explicitly implicates friction and shear in the pathogenesis and exacerbation of pressure ulcers. The paper states *"Does friction alone cause a pressure ulcer? No. Friction can cause minor to substantial skin impairment, however, friction alone is not a direct cause of a*	Thank you for your comment. The GDG did not conduct a review with the aim of identifying risk factors for pressure ulcer development and instead, chose to provide recommendations for healthcare professionals on the best method of risk assessment to use, given the range of tools and scales available.

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							'pressure ulcer', but rather is a risk factor that may contribute to or exacerbate pressure ulcer development due to the shear it creates. That is, friction causes the shear strain in the tissue, which can increase the risk of tissue breakdown and lead to pressure ulcers." Again, this has not been referred to in the Full or NICE versions. An allegory of the importance of managing shear in pressure ulcers is managing hypertension, cholesterol, and smoking in coronary heart disease.	However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.
144	SH	APA Parafricta Ltd	17	FULL	1	12	Could you consider adding "the need for friction and shear relief at specific sites" as a separate sub-bullet? During repositioning special attention should be given to friction/ shear if patients need repositioning. Below "pressure redistributing devices" please consider adding "friction and shear reduction devices".	Thank you for your comment. We have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development. Following discussion on the topics to be included in the guideline, the GDG decided to focus upon the effectiveness of pressure redistributing devices on pressure ulcer prevention. The GDG have prioritised the effectiveness of pressure redistributing devices because the decision was made that, due to the number of devices available, we would look at reducing pressure as the primary cause of pressure ulcers, rather than friction and shear. However, we have highlighted in the introduction of the full guideline the

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								potential role of shear and friction to pressure ulcer development.
222	SH	Tissue Viability Society	18	FULL	1	12	'moisture may all have combined in different degrees' . this does not read well	Thank you for your comment, this has been amended.
221	SH	Tissue Viability Society	17	FULL	1	12	Similarly 'It has been widely 'known' for many years that pressure ulcers are nearly always preventable'. There is no evidence for this statement. It is important that the background section does not reinforce unsubstantiated beliefs about avoidable and unavoidable pressure ulcers.	Thank you for your comment, this has been amended.
119	SH	FDUK (The Foot in Diabetes UK) Executive Committee	1	FULL	1.1.1	10	This guideline should cover people in non NHS care homes who are often the most vulnerable for developing a pressure ulcer	Thank you for your comment. This guideline provides recommendations for care provided or commissioned by the NHS only and non-NHS care settings may choose to adopt the guidance if they wish because we also have a remit for social care.
55	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	21	FULL	1. 3	General	The guidance needs to be split between adults and paediatrics	Thank you for your comment. The recommendations for neonates, children and young people have been separated within the NICE guideline and full guideline chapters.
56	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	22	FULL	1.3	General	Seating has not been considered and should be	Thank you for your comment. The GDG agree and recommendation 1.1.16 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered.
57	SH	Newcastle upon	23	FULL	1.3	Ge	With regards to therapy beds: you discuss using	Thank you for your comment.

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		Tyne Hospitals NHS Foundation Trust				neral	high quality foam mattress or dynamic products. However what about the new hybrid products, what about the static air products or gel mattresses which we use in 98.5% of our patients. (We only use 20-30 Low Air Loss mattresses for our 1850 patients; critical care uses a mixture of 50% gel products and 50% alternating pressure redistribution mattress – which incidentally has not reduced their incidence of pressure damage since introduction…..)	Insufficient evidence was identified relating to these products and none showed a clear benefit for the prevention of pressure ulcers, therefore the GDG chose to recommend the use of high specification foam mattresses for people at risk of developing a pressure ulcer.
120	SH	FDUK (The Foot in Diabetes UK) Executive Committee	2	FULL	1.1.2	10	Neurological condition – may be more explicit if it reads… "Specific neurological condition or other conditions which result in neuropathy i.e. diabetes" In order that diabetes related neuropathy will be considered.	Thank you for your comment. Following further discussion regarding recommendation 1.1.2, we have clarified the list of examples to highlight that people with significant loss of sensation should be risk assessed in primary and community care settings, and emergency departments. We have also amended the recommendation to include a footnote highlighting that the examples provided are not an exhaustive list.
121	SH	FDUK (The Foot in Diabetes UK) Executive Committee	3	FULL	1.4.13	20	Peripheral Arterial Disease should be mentioned specifically when assessing the need to debride	Thank you for your comment. We agree that peripheral arterial disease is an important factor in the development of pressure ulcers and should be managed in line with NICE clinical guideline 147 'Lower limb peripheral arterial disease'.
122	SH	FDUK (The Foot in Diabetes UK) Executive Committee	4	FULL	1.4.14	20	Sharp debridement should only be carried out by trained professionals	Thank you for your comment. It is the underlying ethos of NICE recommendations that they are carried out by an appropriately trained

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								healthcare professional. However, we have highlighted this point in the 'Linking evidence to recommendations' section 8.4.1.
123	SH	FDUK (The Foot in Diabetes UK) Executive Committee	5	FULL	1.4.15	21	Peripheral Arterial Disease should be addressed before the use of Larvae therapy otherwise the wound will not heal	Thank you for your comment. Recommendation 1.4.15 recommends that larval therapy should not be used routinely for debridement of pressure ulcers.
124	SH	FDUK (The Foot in Diabetes UK) Executive Committee	6	FULL	1.4.22	22	A moist healing environment is contraindicated in the presence of significant PAD	Thank you for your comment however, we did not look for evidence in relation to PAD as it is outside the scope of the guideline. Recommendations on the management of lower limb peripheral arterial disease can be found in NICE clinical guideline 147 'Peripheral arterial disease'.
125	SH	FDUK (The Foot in Diabetes UK) Executive Committee	7	FULL	1.4.23	22	Simple dry dressing can be used in the presence of significant ischaemia	Thank you for your comment however, we did not look for evidence in relation to significant ischaemia as it is outside the scope of the guideline. Recommendations on the management of lower limb peripheral arterial disease can be found in NICE clinical guideline 147 'Peripheral arterial disease'.
126	SH	FDUK (The Foot in Diabetes UK) Executive Committee	8	FULL	2.1	26	Sharp debridement should be carried out by a trained professional. Clearer wording on debridement and sharp debridement would be helpful when related to heel pressure ulcers with adherent / fibrous slough and the role of non surgeons with the skills to do it such as Specialist Podiatrists and Tissue Viability Nurses.	Thank you for your comment. It is the underlying ethos of NICE recommendations that they are carried out by an appropriately trained healthcare professional. However, we have highlighted in the 'Linking evidence to recommendations' section 8.4.1.

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81	SH	Leonard Cheshire disability	3	FULL	2.3	14, lines 21-29	As for point 2 – clarity for social care provision perhaps have as an example alongside 'private settings'.	Thank you for your comment. The guideline is applicable to all settings in which NHS care is commissioned or provided however, non-NHS settings, including social care, may choose to adopt the guidance.
187	SH	Royal College of Nursing	5	FULL	2.4	15	*What this guideline does not cover* • *Prevention and management of pressure ulcers caused by devices.* • *Prevention and management of Kennedy terminal ulcers.* Are there any plans to include these in future or specific guidance? It would be helpful to know.	Thank you for your comment. There are currently no plans for specific guidance to be developed in these areas.
210	SH	Tissue Viability Society	6	FULL	2.4	15	Device related and end of life exclusions are appropriate, but in the current climate of NHS targets and pressure ulcer reporting to commissioners (ie CQUINs) it would be helpful to include rationale behind this exclusion. For instance the usual pathways and tools of risk assessment and prevention are not relevant to these groups of pressure damage. Are there plans to include these in future or specific guidance?	Thank you for your comment. Device related pressure ulcers and end of life care were considered to have specific prevention and management strategies that are beyond the scope of the guideline.
82	SH	Leonard Cheshire disability	4	FULL	2.4	15, line 5	Given the scale of the document and the rate of problems with devices causes ulcers why has this been excluded?	Thank you for your comment. During development of the scope, devices with pressure ulcers were excluded from the guideline, given the number of prevention and management strategies included.

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								The size of the existing document reflects the breadth of review questions relating to non-device related pressure ulcers.
188	SH	Royal College of Nursing	6	FULL	3.1	24	Review Question table: Hyperbaric oxygen and others in critical outcomes column "*Side effects (pain, problems with vacuum sealing, reaction of foam)"* This seems to be related to NPWT not hyperbaric oxygen?	Thank you for your comment. This has been corrected.
224	SH	Tissue Viability Society	20	FULL	3.1	24	Hyperbaric oxygen and others in critical outcomes column "*Side effects (pain, problems with vacuum sealing, reaction of foam)"* These are related to NPWT not hyperbaric oxygen	Thank you for your comment, this has been amended.
174	SH	The James Cook University Hospital, The Golden Jubilee Regional Spinal Cord Injury Centre	8	FULL	4		As far as dressings are concerned, it is agreed that anything can be put on a pressure ulcer, except the patient (or a gauze dressing).	Thank you for your comment. There was limited evidence identified to allow the GDG to recommend the use of a specific dressing type. However, the GDG agree that gauze dressings should not be used to treat pressure ulcers.
212	SH	Tissue Viability Society	8	FULL	5.1	50	The algorithm has skin assessment as a different process to risk assessment and something which follows risk assessment. It is not possible to assess risk without establishing skin status. See point 13 and 15 below	Thank you for your comment. The GDG wished to look at tools to assess risk and techniques to establish skin status and have therefore developed recommendations to reflect this.
84	SH	Leonard Cheshire disability	6	FULL	5.1	50, pressure redistri	'wheelchair user' – same requirements for pressure redistributing cushion for someone who sits for long periods in an arm chair	Thank you for your comment. The GDG agree and recommendation 1.1.16 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered.

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						bution devices		
83	SH	Leonard Cheshire disability	5	FULL	5.1	50, skin assessment	'offer….. assessment by a trained healthcare professional' – IF this guidance applies to social care what are the expectations of care staff (in non-nursing homes)? They should be able to identify if a problem exists and what action to take ie they need to undertake some sort of skin assessment.	Thank you for your comment. The guideline is applicable to all settings in which NHS care is commissioned or provided however, non-NHS settings, including social care, may choose to adopt the guidance.
85	SH	Leonard Cheshire disability	7	FULL	5.2	P52/53	I don't understand the numbered references lines 16, 25, 33, 38, 2, 6, 12, 20, 23	Thank you for your comment. Further detail on the recommendations included in the section 'Key priorities for implementation' can be found in the relevant 'Linking evidence to recommendations' sections of the full guideline.
214	SH	Tissue Viability Society	10	FULL prevention	5.2	52	This statement confusing 'carry out on', 'which does not involve', 'only if'. Carry out and document an assessment of pressure ulcer risk on initial contact for adults receiving NHS care which does not involve admission to secondary care or a care home (for example, care 8 received at a GP surgery or an accident and emergency department) only if they have a risk factor, 9 for example: See also item 21 below	Thank you for your comment. For clarity, the wording of this recommendation (recommendation 1.1.2 of the published guideline) has been amended and combined with recommendation 1.1.1 (of the draft consultation version).
216	SH	Tissue Viability Society	12	FULL	5.2	52	A care plan is recommended only for patients at 'elevated risk'. Given our limited ability to distinguish between patients who are and are not likely to develop a pressure ulcer, and the expected	Thank you for your comment. We agree that preventative interventions would be provided to an individual at risk of developing a pressure ulcer, for

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							standards of care in the NHS, it would be difficult to justify in practice identifying a patient as 'at risk' and not providing any preventative interventions and plan of care.	example, recommendation 1.1.8 highlights that adults at risk of a pressure ulcer should be repositioning at least every 6 hours and that the frequency of repositioning required should be documented. It is therefore likely that healthcare professionals would choose to develop an individualised care plan for some individuals who are considered to be at risk of developing a pressure ulcer. However, the GDG felt that a specific individualised care plan was needed for all individuals at high risk of developing a pressure ulcer only.
217	SH	Tissue Viability Society	13	FULL	5.2	52	Assessment of a patient's risk of pressure ulcer development should include skin status (which may be established through history taking or by skin inspection, depending upon context). Alterations to intact skin/presence of existing pressure ulcer are key risk factors for pressure ulcer development. It is not appropriate to 'Offer adults who have been assessed as being at elevated risk of developing a pressure ulcer a skin assessment by a trained healthcare professional, since assessment of elevated risk should include a skin assessment'. A skin assessment is not secondary clinical information, it is primary information.	Thank you for your comment. We agree and the skin assessment recommended in recommendation 1.1.5 for those considered at high risk is intended to compliment any formal risk assessment carried out by the healthcare professional.

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							See point 8 above and 15 below The situation in the acute and community setting are also different in terms of how skin status may be determined – see section 21 below	
87	SH	Leonard Cheshire disability	9	FULL	5.3	P56 line 34	What is the definition of regular in this context?	Thank you for your comment. The recommendation on wheelchair assessment was developed using a Delphi consensus approach. No optimum frequency for wheelchair assessments were identified therefore, the GDG chose to highlight that these assessment should take place regularly, depending upon the needs of the individual.
86	SH	Leonard Cheshire disability	8	FULL	5.3	P53 line 25-26	Surely this should be extended to all care homes regardless of NHS funded care, many will be required to do this as part of commissioned/contracted services.	Thank you for your comment. The guideline is applicable to all settings in which NHS care is commissioned or provided however, non-NHS settings, including social care, may choose to adopt the guidance.
36	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	2	FULL	5.3	53	2. this sentence needs rewording, not sure what you are recommending	Thank you for your comment. We agree that this could be clearer and this has been amended.
37	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	3	FULL	5.3	53	3. Please do not use the word "Consider". Change to: " Use a validated…."	Thank you for your comment. As per the NICE guidelines manual 2012 http://publications.nice.org.uk/the-guidelines-manual-pmg6 , the wording of NICE recommendations is intended to reflect the strength of the evidence supporting it. There was

ID	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								insufficient evidence identified to support the use of a validated tool and therefore the GDG chose to develop a weaker, 'consider' recommendation to reflect this.
40	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	6	FULL	5.3	54	10. This sentence is not grammatically correct. Needs rewording	Thank you for your comment. However, we feel that this recommendation is clear and no changes have been made.
41	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	7	FULL	5.3	54	12. Turning for the "at risk" patient should be 2-3h.	Thank you for your comment. Two hourly repositioning was not found to be cost-effective when compared to 4 and 6 hours. The recommendation regarding frequency of repositioning is recommending 4 hours as the minimum frequency, and therefore we have worded the recommendation to state 'at least every 4 hours'.
42	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	8	FULL	5.3	54	13. remove sentence. It is confusing to separate "at risk" with "at high risk" unless you specify which assessment tool we should be using.	Thank you for your comment. There was insufficient evidence identified to support the use of a specific assessment tool. The GDG acknowledged that the thresholds for defining individuals at high and very high risk varied significantly between tools and therefore, chose to develop a definition for individuals at risk and at high risk. A definition of both terms has been included on page 13 of the NICE guideline.
38	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	4	FULL	5.3	54	7. This sentence is not grammatically correct. Needs rewording	Thank you for your comment. However, we feel that this recommendation is clear and no changes have been made.

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39	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	5	FULL	5.3	54	9. Remove "Consider"	Thank you for your comment. As per the NICE guidelines manual 2012 http://publications.nice.org.uk/the-guidelines-manual-pmg6 , the wording of NICE recommendations is intended to reflect the strength of the evidence supporting it. There was insufficient evidence identified to support the use of skin assessment and therefore the GDG chose to develop a weaker, 'consider' recommendation to reflect this.
43	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	9	FULL	5.3	55	14. 2 hours. Not 4 hours, not enough.	Thank you for your comment. No clinical difference was found between repositioning at alternate intervals of 2 and 4 hours and repositioning every 4 hours. 2 and 4 hourly turning was also not found to be cost-effective compared to 4 hourly turning (see Appendix L). The recommendation regarding frequency of repositioning is recommending 4 hours as the minimum frequency, and therefore we have worded the recommendation to state 'at least every 4 hours'.
44	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	10	FULL	5.3	55	15. 2-3 h	Thank you for your comment. No clinical difference was found between repositioning at alternate intervals of 2 and 4 hours and repositioning every 4 hours. Two and 4 hourly turning was also not found to be cost-effective compared to 4 hourly turning (see Appendix L). The recommendation regarding frequency of repositioning is

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								recommending 4 hours as the minimum frequency, and therefore we have worded the recommendation to state 'at least every 4 hours'.
45	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	11	FULL	5.3	55	16. Remove sentence. It is confusing to separate "at risk" with "at high risk" unless you specify which assessment tool we should be using. 17. Remove sentence. It is confusing to separate "at risk" with "at high risk" unless you specify which assessment tool we should be using.	Thank you for your comment. There was insufficient evidence identified to support the use of a specific assessment tool. The GDG acknowledged that the thresholds for defining individuals and high and very high risk varied significantly between tools and therefore, chose to develop a definition for individuals at risk and at high risk. For clarity, a definition of who is considered to be 'at risk' and 'at high risk' has been included in the NICE guideline.
46	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	12	FULL	5.3	55	20. IF *any patients* decline repositioning, etc (not just children)	Thank you for your comment. The recommendations relating to neonates, infants, children and young people were developed using a Delphi consensus methodology. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults.
47	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	13	FULL	5.3	55	39. at ~~elevated~~ risk	Thank you for your comment. There was insufficient evidence identified to support the use of a specific assessment tool. The GDG acknowledged that the thresholds for

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								defining individuals and high and very high risk varied significantly between tools and therefore, chose to develop a definition for individuals at risk and at high risk. For clarity, a definition of who is considered to be 'at risk' and 'at high risk' has been included in the NICE guideline.
51	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	17	FULL	5.3	56	34. Who is responsible to ensure "regular" assessment is been offered?	Thank you for your comment. It is the responsibility of individual NHS trusts to identify who is responsible for the provision of wheelchair assessment.
48	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	14	FULL	5.3	56	30. ~~Consider…~~. Provide/offer	Thank you for your comment. As per the NICE guidelines manual 2012 , http://publications.nice.org.uk/the-guidelines-manual-pmg6 the wording of NICE recommendations is intended to reflect the strength of the evidence supporting it. There was insufficient evidence to support the use of high specification foam theatre mattresses and therefore the GDG chose to develop a weaker, 'consider' recommendation to reflect this.
49	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	15	FULL	5.3	56	31. ~~Consider…~~. Provide/offer	Thank you for your comment. As per the NICE guidelines manual 2012 http://publications.nice.org.uk/the-guidelines-manual-pmg6 , the wording of NICE recommendations is intended to reflect the strength of the evidence supporting it. There was insufficient evidence to support use of high

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								specification foam cushions and therefore the GDG chose to develop a weaker, 'consider' recommendation to reflect this.
50	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	16	FULL	5.3	56	32. no overlay should be recommended	Thank you for your comment. Results of the Delphi consensus suggested that there may be some situations in which the use of an overlay is helpful in these populations and the GDG therefore chose to recommend the use of a high specification mattress or overlay. Further detail of the trade-off between benefits and harms can be found in section 12.2.2.
52	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	18	FULL	5.3	56	38~~. Consider~~ Use Barrier preparation	Thank you for your comment. As per the NICE guidelines manual 2012 http://publications.nice.org.uk/the-guidelines-manual-pmg6 , the wording of NICE recommendations is intended to reflect the strength of the evidence supporting it. There was insufficient evidence to support use of a barrier cream and therefore the GDG chose to develop a weaker, 'consider' recommendation to reflect this.
53	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	19	FULL	5.3	56	31. Comment: Teaching sessions should be documented	Thank you for your comment. It is the responsibility of individual trusts to provide further detail on how these sessions should be provided.
54	SH	Newcastle upon Tyne Hospitals NHS Foundation Trust	20	FULL	5.3	56	What about Bowel Management systems in the prevention of moisture lesions – Acute care. This should be discussed/ included in the guidance	Thank you for your comment. As outlined in the scope of the guideline, the role of barrier creams in the prevention of moisture lesions was

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								within the scope of the current guideline. However, the GDG did not choose to prioritise other strategies for the prevention of moisture lesions.
176	SH	Papworth Hospital NHS Foundation Trust	2	FULL	5.3.1	54	I appreciate that it is difficult to find evidence on when to reassess a patients' risk, however, if left to clinical judgement in junior or busy staff this re risk assessment often doesn't happen. In RCA reviews it has been found in avoidable PU development that the patients condition had changed but PU risk assessment had not been done. Can this guideline not specify if there is a change in clinical status or a minimum of once a week whilst a patient is in secondary care or care home.	Thank you for your comment. Frequency of risk assessment was not prioritised by the GDG as risk assessment methods were prioritised instead. Therefore a review was not conducted on the frequency of risk assessment. However, the GDG chose to develop recommendation1.1.4 to highlight that a reassessment of risk should be conducted with any change in clinical status. The GDG felt that the frequency of reassessment was likely to be dependent upon the care setting.
177	SH	Papworth Hospital NHS Foundation Trust	3	FULL	5.3.13	54	Again no guidance on a timeline for this skin assessment in the at risk individual. I repeat an actual prescribed timeline such as within x number of hours actually helps TVNs/organisations enforce this.	Thank you for your comment. The GDG felt the timing of skin assessment would vary depending upon the care setting in question. However, it is likely that this would take place on admission to secondary care or to a care home, in these scenarios.

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175	SH	Papworth Hospital NHS Foundation Trust	1	FULL	5.3.25	53	No timeline on risk assessment to be carried out when patient risk assessed on admission to secondary care or care home. An actual prescribed timeline such as within x number of hours actually helps TVNs/organisations enforce this. Otherwise, in theory, organisations could suggest risk assessment could be carried out days after admission leaving patients potentially at risk. The panel has looked at the evidence behind risk assessment tools, but there appears no emphasis has been placed on the timeliness of the risk assessment especially in view of recent studies looking at deep musculoskeletal cell damage (Loeraker et al, 2010).	Thank you for your comment. Frequency of risk assessment was not prioritised by the GDG as risk assessment methods were prioritised instead. Therefore a review was not conducted on the frequency of risk assessment. However, the GDG chose to develop recommendation1.1.4 to highlight that a reassessment of risk should be conducted with any change in clinical status. The GDG felt that the frequency of reassessment was likely to be dependent upon the care setting.
178	SH	Papworth Hospital NHS Foundation Trust	4	FULL	5.3.33 & 37	54	The wording used here "at risk" and "at elevated risk" can be very confusing for junior staff – this needs clarifying by guiding staff to the later definitions on page 59.	Thank you for your comment. We have provided the definition of each term at the start of the NICE guideline (see page 13) for clarity.
168	SH	The James Cook University Hospital, The Golden Jubilee Regional Spinal Cord Injury Centre	2	FULL	6		SCI patients differ from able bodied people and also from the significant majority of neurologically impaired people in five significant respects. • They are able to mobilise only when seated. Most pressure ulcers in these patients occur over the sacrum or ischia. This means that mobilisation is accompanied by pressure on the pressure ulcer for the entire duration of mobilisation. • They have insensiate skin and so do not	Thank you for your comment. A large proportion of people with neurological impairment are at risk of developing a pressure ulcer, including those with spinal cord injury. Recommendation 1.1.2 highlights that the needs of these individuals should be considered. Bed rest was not reviewed as a topic

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							register the discomfort that a normal patient would experience with prolonged pressure. • Many are unable by themselves to relieve pressure when seated. • The sore is at risk of scuffing or other minor trauma during transfers. • More vulnerable patients with high lesions normally have a lower arterial blood pressure reducing the effectiveness of pre-capillary vascular dilatation. A spinal cord injured patient can mobilise only when seated. Therefore, to relieve the direct pressure on the pressure ulcer the only alternative is restriction of mobilisation, ie, bed rest. It is universal practice that Spinal Cord Injury Centres in the U.K and Europe to treat pressure ulcers in sacral and ischial areas by bed rest. This is continuous until the pressure sore is healed. In established necrotic ulcers this can take weeks or even months. This is often undertaken within spinal cord injury centres, with very prolonged admission or at home with out reach supervision. It is clearly extremely restricting for the patient. Unfortunately over many years, it has been found that continuing the pressure on the pressure ulcer by mobilisation inevitably leads to failure of healing or significant progression. All Spinal Cord Injury Centres have experienced difficulties as a result of conflicting advice provided by tissue viability nurses either in hospital settings or in the community. Many of these professionals advise that weight bearing (i.e. sitting) may be permitted. This of course places pressure on the pressure ulcer. In our view this is a result of failure to appreciate the very significant differences between spinal cord injured patient and the majority	for consideration in the guideline as it was not identified by stakeholders or the GDG during development of the scope.

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							of other patients. In our view this has resulted on occasion in significant detriment to patient management. It is recognised that there is little or no published evidence on the value of bed rest, neither in the spinal cord injury population nor indeed in any other population. The GDG has neither considered the question of bed rest nor the specific issues of management of pressure ulcers in the spinal cord injured population. This would be of great benefit to these particularly vulnerable patients. Alternatively, it would be of a very great help if it could be explicitly noted that the issues of bed rest and of the particular needs of the spinal cord injured population were not specifically considered. This would ensure that the guidance does not give implied support to the view that management in the spinal cord injury patients is the same as management in other patient groups, or that sitting on a pressure ulcer is acceptable	
172	SH	The James Cook University Hospital, The Golden Jubilee Regional Spinal Cord Injury Centre	6	FULL	6		No mention is made of the use of padded shower chairs and toilet seat etc in the prevention strategy in spinal cord injured patients.	Thank you for your comment. The GDG agree and recommendation 1.1.16 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered.
173	SH	The James Cook University Hospital, The Golden Jubilee Regional Spinal	7	FULL	6		There is no mention of use of pillows in a pressure reduction strategy. These are commonly used to maintain position in spinal cord injured patients and also they assist in spasm reduction which reducing both pressure and mechanical trauma by repetitive	Thank you for your comment. No evidence was found for the use of pillows in any population. This is more specifically related to the management of spinal cord injuries

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		Cord Injury Centre					movement.	only rather than the management of pressure ulcers.
169	SH	The James Cook University Hospital, The Golden Jubilee Regional Spinal Cord Injury Centre	3	FULL	6	8	Even a high specification foam mattress is inadequate for some spinal cord injured patients who should be nursed on alternating pressure mattresses.	Thank you for your comment. The review question on pressure redistributing devices considered people with a spinal cord injury as strata. However, there was a lack of evidence in this population to suggest that there was a benefit to providing an alternating pressure mattress over a high specification foam mattress. The GDG were therefore not able to provide a stronger recommendation than to consider the use of alternating pressure mattress for individuals who are at high risk of developing a pressure ulcer, including people with a spinal cord injury.
189	SH	Royal College of Nursing	7	FULL	6.1	58	Line 6: *It has been widely known for many years that pressure ulcers are nearly always preventable* Suggest reword this statement – there is little evidence to support it. It may be more accurate to state 'accepted' rather than 'widely known'.	Thank you for your comment. This has been amended.
213	SH	Tissue Viability Society	9	FULL	6.1.1	59	Reference Colman – should be Coleman	Thank you for your comment. This has been corrected.
219	SH	Tissue Viability Society	15	FULL	6.1.1	59	Elevated Risk – two issues: Location of definition	Thank you for your comment. The definition is provided at the beginning

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							The definition of 'elevated risk' is not detailed until page 59, ie after a number of recommendations relating to patients with 'elevate risk' are made Definition itself The distinction between 'at risk' and 'elevated risk' are fundamentally flawed, compounded by the 'definition' of elevated risk which does not include key risk factors for pressure ulcer development established through epidemiological research. Key risk factors skin perfusion and skin status (including the presence of existing pressure ulcers) are excluded from the description of 'elevated risk' despite strong epidemiological evidence. The 'risk of nutritional deficiency' is included in the definition. What is 'risk of nutritional deficiency'? This seems to be too broad for clinical translation. There is some epidemiological evidence that actual nutritional deficits/poor food intake are risk factors, but no evidence that people 'at risk of nutritional deficiency' are at increased risk of pressure ulcer development.	of the full guideline, directly after the summary of recommendations. However, we acknowledge that this definition should be made clearer in the NICE version of the guideline, and it has been included at the beginning of the guidance on page 13. The examples included in the definition of high risk are provided as examples only and are not intended to form an exhaustive list of risk factors. Healthcare professionals should use their clinical judgement and consider using a validated risk assessment tool in identifying an individual's risk status (see recommendation 1.1.1 – 1.1.4). The GDG felt that people at risk of nutritional deficiency (for example, adults who are unable to ingest food orally) are potentially at increased risk of pressure ulcer development and that they should be considered to be at high risk.
220	SH	Tissue Viability Society	16	FULL	1 and 6.1	12 and 58	Pressure ulcers are 'often' an example of such avoidable 4 harm occurring and their prevention is now a priority for the NHS. There is no data available on the numbers of avoidable and unavoidable harm in relation to pressure ulcer development. The word 'often' needs to be amended.	Thank you for your comment, this has been amended.
190	SH	Royal College of	8	FULL	7.2.1	96	Trade off between clinical benefits and harms:	Thank you for your comment. We

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		Nursing					*The GDG felt that all people who were considered potentially at risk of developing a pressure ulcer should receive a pressure ulcer risk assessment. This would apply to all individuals admitted to secondary care and those who receive on-going care in primary care and community settings. The GDG emphasised that people receiving care in the community and in primary care may also be at risk of developing a pressure ulcer and should thus be assessed for risk.* This is a confusing paragraph given that earlier the recommendation states *Carry out and document an assessment of pressure ulcer risk on initial contact for adults receiving NHS care which does not involve admission to secondary care or a care home (for example, care received at a GP surgery or an accident and emergency department) only if they have a risk factor, for example:* On the face of it the guideline seems to be recommending slightly different things. The latter suggests even one visit to the GP should include prompts to answer the triggers mentioned that may determine if risk is likely. If yes then GPs will have to undertake formal risk assessment. There are time, education and practice implications with this recommendation as this would not normally be happening now.	agree that this may cause confusion and have therefore changed the order of the recommendations and made changes to the LETR for clarity. The recommendation gives examples of the type of factors that may suggest risk of pressure ulcers in order that a full risk assessment be carried out and it not intended to be exhaustive. Skin assessment should be carried out if the patient is deemed to be at high risk. Recommendation 1.1.2 states that all people who have a risk factor should be risk assessed to identify pressure ulcer risk in settings which do not involve admission. The healthcare professional may consider using a validated scale to support clinical judgement as part of this assessment. These individuals are at significantly increased risk of developing a pressure ulcer and therefore, the GDG believes that it is the responsibility of all healthcare professionals to identify and acting upon this risk. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to

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							And so *However, risk assessment is current best practi* *GDG do not anticipate an impact on resource u* This comment is not strictly the case when taking into account GPs undertaking risk assessment. In relation to this the guidance would also suggest that if the individual was deemed at risk they should be offered a skin assessment – there are time implications with regard to this for GPs if the patient consents to this assessment. The guidance around skin assessment seems biased towards the acute setting – perhaps more commentary is required on when to undertake this in the variety of community settings. For instance if a GP ascertains risk then can they refer for more formal assessment by practice nurse?	be implemented.
225	SH	Tissue Viability Society	21	FULL	7.2.1	96	*The GDG felt that all people who were considered potentially at risk of developing a pressure ulcer should receive a pressure ulcer risk assessment. This would apply to all individuals admitted to secondary care and those who receive on-going care in primary care and community settings. The GDG emphasised that people receiving care in the community and in primary care may also be at risk of developing a pressure ulcer and should thus be assessed for risk.* This is a confusing paragraph given that earlier	Thank you for your comment. However, we disagree. Recommendation 1.1.2 states that all people who have a risk factor should be risk assessed to identify pressure ulcer risk in settings which do not involve admission. The healthcare professional may consider using a validated scale to support clinical judgement as part of this assessment. These individuals are at a significantly increased risk of developing a pressure ulcer. Thus the GDG

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							the recommendation states *Carry out and document an assessment of pressure ulcer risk on initial contact for adults receiving NHS care which does not involve admission to secondary care or a care home (for example, care received at a GP surgery or an accident and emergency department) only if they have a risk factor, for example:* On the face of it they seem to be recommending slightly different things. The latter suggests even one visit to the GP should include prompts to answer the triggers mentioned that may determine if risk is likely. Is this really practical? In patients with the triggers, then GP will have to undertake formal risk assessment. There are time, education and practice implications with this as this would not normally be happening now. And so However, risk assessment is current best practice a not anticipate an impact on resource use This comment isn't strictly the case when taking into account GPs undertaking risk assessment. In relation to this the guidance would also suggest that if the individual was deemed at risk they should be offered a skin assessment – there are time implications with regard to this for GPs if the patient consents to this assessment. The guidance around skin assessment seems biased towards the acute	believes that it is the responsibility of all healthcare professionals to identify and act upon this risk, regardless of setting The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.

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							setting – perhaps more commentary on when to undertake this in the variety of community settings. For instance if a GP ascertains or is concerned about risk then they should refer for more formal assessment by district nurses?	
191	SH	Royal College of Nursing	9	FULL	7.2.1	97	Box point 5. Spelling *Develop and document AN individualised...*	Thank you for your comment, this has been amended**.**
226	SH	Tissue Viability Society	22	FULL	7.2.1.	97	Typo: Develop and document AN ……	Thank you for your comment, this has been amended.
192	SH	Royal College of Nursing	10	FULL	7.2.1	98	Economic costs - Time implications - If GP determines risk on first visit then this will prompt referral to Practice or District Nurse to ensure care planning. If GP do it then there are time implications for GP surgery time slots.	Thank you for your comment. It is acknowledged within the LETR that there will be resource implications associated with the impact of staff time of carrying out risk assessments, The GDG took this into account when qualitatively assessing the cost-effectiveness of this recommendation. This paragraph has been amended slightly to clarify that there may be an upfront impact on resources.
227	SH	Tissue Viability Society	23	FULL	7.2.1	98	As per point 21 above Time implications. If GP determines risk on first visit then this will prompt referral to Practice or District Nurse to ensure care planning. If GP to do it then there are time implications for GP surgery time slots.	Thank you for your comment. It is acknowledged within the LETR that there will be resource implications associated with the impact of staff time of carrying out risk assessments, The GDG took this into account when qualitatively assessing the cost-effectiveness of this recommendation. This paragraph has been amended slightly to clarify that there may be an upfront impact on resources.

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92	SH	Neurocare Europe Limited	2	FULL	7.5 Electrotherapy	General-Conclusions from clinical trials	Your conclusion is that electrotherapy is not recommended on the basis of your analysis of the 14 clinical trials which met your inclusion criteria. Over the last 20 years many competent advisory bodies have considered many of these and a further 20/25 trials which met their own inclusion criteria in arriving at fundamentally different conclusions from your own. All have concluded that evidence supporting the use of electrotherapy in treating ulceration is particularly robust (Grade 1 or A) particularly in treating pressure ulcers. Space precludes a detailed review of all these studies but we have sought below to summarise and represent their conclusions .	Thank you for your comment. The guideline considered pressure ulcers only and therefore, the GDG chose to exclude studies of other wounds. The GDG also chose to include only randomised controlled trials, where these were available, as the highest level of evidence. The studies found in the current review were very small and showed no clinical benefit for the complete healing of pressure ulcers. For the outcome 'healing rate', the studies were very small and log transformations were not carried out on the data, which further downgraded their results. The GRADE rating was low to very low overall. The GDG also thought that electrotherapy was likely to be of greater benefit for grade 3 and 4 pressure ulcers and therefore we analysed this data separately but found no clinical benefit for electrotherapy over placebo.
94	SH	Neurocare Europe Limited	4	FULL	7.7 Economic Considerations		In August 2009 our company commissioned an economic assessment from the MATCH organisation which concluded in a study which mainly considered diabetic ulcers that if our device performed as expected in the wound healing application it would be cost effective and cost saving. We would be happy to make this document available to the GDG.	Thank you for your comment. It was agreed by the GDG that data based on other types of wounds (including diabetic ulcers) would not be reviewed. The GDG felt that other types of wounds were significantly different in etiology from pressure ulcers and that it may not be appropriate to extrapolate.
215	SH	Tissue Viability	11	FULL	7.1.8.1	91	Throughout the presentation of results there are	Thank you for your comment. The

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		Society			And General		statements such as '3500 patients with 523 pressure ulcers'. Two issues: 1. Is this 523 patients with PUs or x patients with 523 PUs. 2. It needs to be clear that the literature reviewed was prospective and that of 3500 patients, 532 developed new pressure ulcers.	protocol developed by the GDG was for prospective studies only (see Appendix C) and the data were extracted for the number of patients with pressure ulcers, as opposed to the number of pressure ulcers. We have amended the relevant text and tables to clarify this.
193	SH	Royal College of Nursing	11	FULL	8.1	100	Line 10. *Lifting* is not correct term, 'moving' is better	Thank you for your comment, we agree and this has been amended.
228	SH	Tissue Viability Society	24	FULL	8.1	100	Lifting is not correct term, moving is better	Thank you for your comment, we agree and this has been amended.
194	SH	Royal College of Nursing	12	FULL	8.5	111	Skin assessment: There should be mention of skin assessment in people with a darker skin colour in this section.	Thank you for your comment. We have added a footnote to highlight that non-blanchable erythema may appear differently in skins of darker tones.
229	SH	Tissue Viability Society	25	FULL	8.5.1	111	Skin assessment. There should be some mention of skin assessing in people with a darker skin colour in this section.	Thank you for your comment. A footnote has been included for clarification.
195	SH	Royal College of Nursing	13	FULL	9.3	153	Repositioning: Perhaps include a recommendation that more frequent repositioning may be necessary if skin marking/erythema occurs? Recommendation 12: Recommends minimum 4 hours or 6 hours according to risk. What of those living at home who would need carers to deliver this? Not all areas provide this level of input overnight. This may impact economically in some areas in the community setting. The guideline does not seem to consider this or	Thank you for your comment. Recommendation 1.1.8 and 1.1.9 highlight that people at risk and at high risk should be repositioned every 6 and 4 hours at a minimum and the frequency of repositioning should be tailored to the specific needs of the individual. The GDG acknowledged that the resource implications may be higher in a community setting, but agreed that the benefits (in terms of future savings and improved quality of life from prevention of pressure

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							directly address this. We would need some further commentary and guidance here. Comments about moving and handling equipment are helpful; the same will be needed to access overnight care.	ulcers) would be such that repositioning every 4 or 6 hours (according to risk) would be cost-effective. This has been added to the evidence and link to recommendations section.
230	SH	Tissue Viability Society	26	FULL	9.3.1	153	Repositioning frequency. Recommends minimum 4 hours or 6 hours according to risk. The current guideline recommendation is not helpful, since in practice it is recommended that more frequent repositioning/offloading is necessary if skin marking/erythema occurs? There needs to be a link between the practice intervention and the patient response. This is 'measured' or evaluated in practice by monitoring the skin condition and 'titrating' interventions (such as mattress provision and repositioning/off-loading) to the patients individual response. The guideline needs to be clearer about decision making to increase or reduce frequency. The specification of minimum repositioning is also problematic, especially if the frequency is not required or practically possible. What of those living at home who would need carers to deliver this? Not all areas provide this level of input overnight. This may impact economically in some areas in the community setting. The guideline does not seem to consider this or	Thank you for your comment. Recommendation1.1.8 and 1.1.9state that people at risk of and at high risk of developing a pressure ulcer should be repositioned at least every 6 hours or every 4 hours respectively. However, this frequency should be tailored according to the needs of the individual. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.

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							directly address this. Needs some further commentary and guidance. Comments about moving and handling equipment are helpful, the same will be needed to access overnight care.	
196	SH	Royal College of Nursing	14	FULL	9.3.2	159	Recommendation 20: The issue of declining repositioning is only mentioned with regard to children. Adults decline too and this requires addressing within the guidance.	Thank you for your comment. The recommendations relating to neonates, infants, children and young people were developed using a Delphi consensus methodology. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults.
231	SH	Tissue Viability Society	27	FULL	9.3.2	159	Recommendation 20. The issue of declining repositioning is only mentioned with regard to children . Adults decline too and this requires addressing within the guidance.	Thank you for your comment. The recommendations relating to neonates, infants, children and young people were developed using a Delphi consensus methodology. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults.
197	SH	Royal College of Nursing	15	FULL	9.3.2	162	Recommendation 22: Reference to recommendation 35 required here.	Thank you for your comment. We have included a cross reference to the relevant recommendation in the 'Linking evidence to recommendations' section of the full guideline.
232	SH	Tissue Viability	28	FULL	9.3.2	162	rec 22. Reference to recommendation 35 here	Thank you for your comment. We

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		Society						have cross referred to this recommendation in the 'Linking evidence to recommendations' section for this recommendation.
88	SH	Leonard Cheshire disability	10	FULL prevention	10	164, line 10	Typo –word 'of' missing between use and cream	Thank you for your comment, this has been amended.
89	SH	Leonard Cheshire disability	11	FULL prevention	10.2.2	165, line 5	Typo – word 'a' missing between of and more	Thank you for your comment, this has been amended.
198	SH	Royal College of Nursing	16	FULL	11.3	195	Nutritional supplements: Recommendation states supplements etc are not recommended where nutritional intake and hydration are adequate. What about where these are inadequate? Some guidance regarding this will be necessary.	Thank you for your comment. It is outside the scope of the current guideline to provide guidance on correcting nutritional deficiencies however, it is implicit that any nutritional deficiencies should be corrected. Recommendations on the provision of nutrition support can be found in NICE clinical guideline 32 'Nutrition support in adults'.
233	SH	Tissue Viability Society	29	FULL	11.3.1	195	Recommendation states supplements etc not recommended where nutritional intake and hydration are adequate. What about where these are inadequate? Some guidance regarding that will be necessary	Thank you for your comment. It is outside the scope of the current guideline to provide guidance on correcting nutritional deficiencies. However, it is implicit that any nutritional deficiencies should be corrected. Recommendations on the provision of nutrition support can be found in NICE clinical guideline 32 'Nutrition support in adults'.
170	SH	The James Cook University Hospital, The	4	FULL	12.0	9	Spinal Cord Injured patients are prone to oedema of the lower limb and feet which retards pressure sore healing. In addition to pressure release strategies,	Thank you for your comment. As outlined in recommendation 1.1.15, adults at high risk of developing a heel

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		Golden Jubilee Regional Spinal Cord Injury Centre					elevation is very important.	pressure ulcer (which may include people with a spinal cord injury) should have a strategy to offload heel pressure. It is likely that this strategy may include elevation strategies.
199	SH	Royal College of Nursing	17	FULL	12.2.1	302	***Intensive care*** *There was no clinical benefit of alternating pressure or constant low pressure mattresses for the prevention of pressure ulcers in people in intensive care. The GDG considered that for these individuals, a high specification foam mattress, provided on admission to intensive care, should be given as a minimum.* It would seem the RCT is needed to guide the guidance….yet the RCTs included are largely deemed of low quality. Why is this the gold standard if the gold standard is never good enough to be included in relevant clinical practice guidance? This particular guidance could result in variation in practice i.e. one of 2 ways - one could have financially conscious managers removing replacement alternating mattresses from ITU and therefore HDU and any other high dependent step down units because the guidance says it is not needed; Or they will ignore the guidance because they do not trust it. They may also extend this to 'if it is not needed in ITU then it is not needed anywhere'.	Thank you for your comment. We look at the highest level of evidence available to answer the review questions, which in this instance, is considered to be randomised control trials. However, we use GRADE methodology to appraise the quality of each study. The GRADE appraisal system takes into account all risk of bias in a study. A fully powered trial will be more likely to show narrow confidence intervals and therefore results will be less likely to be downgraded on imprecision. However if there is other risk of bias in the study then they will be downgraded accordingly. We present this evidence to the GDG, a multidisciplinary group who reach a consensus decision and make the recommendation. Therefore I am afraid we would not seek further consultation of clinicians and managers. We feel that the recommendation is not at odds with clinical practice as

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							Whilst we would appreciate that we do not yet know the answer to this question and maybe the PRESSURE 2 trial will be deemed of high quality enough to provide conclusive guidance; Perhaps if this recommendation is to be included, suggest testing the water with clinicians and managers?	you point out we have stated 'a high specification foam mattress, provided on admission to intensive care, should be a minimum'. Therefore this allows for other devices to be used above this minimum requirement.
90	SH	Leonard Cheshire disability	12	FULL prevention	12.2.2	301	2 sentences don't make sense: 3rd paragraph, 1st sentence – 'sheepskin overlay….of clinical benefit…for preventing **all** grades of ulcers but this did not follow for ulcers of grade **2 and above'** – does this mean the overlay is only of benefit to grade 1 in which case ALL needs to be changed 4th paragraph – last sentence – 'a mattress with….**delayed the onset tool less time**….' Does not make sense.	Thank you for your comment. The evidence demonstrated some benefit for prevention of pressure ulcers of all grades. However, when the prevention of pressure ulcers grade 2 and above was analysed separately, no clinical benefit of sheepskin versus no sheepskin was found. The 4th paragraph has been amended for clarity.
200	SH	Royal College of Nursing	18	FULL	13.3.1	345	Recommendation 36: Perhaps include within the recommendation guidance requesting identifying those individuals specifically at risk of heel damage. Guidance within the recommendation could then include an extensive list of those at risk. Guidance would also need to include clear suggestion that a selection of protection devices may be needed to be offered to patients.	Thank you for your comment. However, no review of the evidence was conducted to identify who may be at risk of developing a heel pressure ulcer and therefore, we have not included a list of risk factors in the recommendation.
235	SH	Tissue Viability Society	31	FULL	13.3.1	345	Recommendation 36 Perhaps include within the recommendation	Thank you for your comment. However, no review of the evidence

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							guidance requesting identifying those individuals specifically at risk of heel damage. Guidance within the recommendation could then include an extensive list of those at risk. Guidance would also need to include clear suggestion that a selection of protection devices may be needed to offer patients.	was conducted to identify who may be at risk of developing a heel pressure ulcer and therefore, we have not included a list of risk factors in the recommendation.
201	SH	Royal College of Nursing	19	FULL	14.2.1	364	Recommendation 38: Consider including 'perspiration' within the recommended examples.	Thank you for your comment. The list provided are examples only and are not intended to be exhaustive.
236	SH	Tissue Viability Society	32	FULL	14.2.1	364	Recommendation 38. Consider including perspiration within the recommendation examples	Thank you for your comment. The list included in this recommendation is provided as examples only and are not intended to be an exhaustive list.
202	SH	Royal College of Nursing	20	FULL	15.1	368	Line 3: Rather than they 'can' be prevented suggest say 'most' can be prevented	Thank you for your comment, this has been amended.
203	SH	Royal College of Nursing	21	FULL	15.1	368	Line 6: please include people with mobility difficulties as this is the key risk factor – 'physical impairment' is clear enough	Thank you for your comment, this has been amended.
237	SH	Tissue Viability Society	33	FULL	15.1	368	As per point 16 above 'they can be prevented if care is taken by people at risk, health care professionals and their carers.' Suggests that all pressure ulcers are avoidable	Thank you for your comment, this has been amended.
239	SH	Tissue Viability Society	35	FULL	15.1	368	The language used to describe at risk people is totally inappropriate – who are people 'who have a deformity'? Is the term sensory impairment meaningful to the public? What is physical	Thank you for your comment. We have amended the text to remove the term deformity. However, we believe that the terms sensory and physical

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							impairment? The language needs simplifying.	impairment are understood by healthcare professionals and the public. A version of the guideline designed for the public will be developed and we will ensure that these terms are clarified within this document.
147	SH	Royal Pharmaceutical Society	2	FULL	15.3	373 - 374	Pharmacists, in primary and secondary care setting have suitable opportunity to discuss treatments and care with their patients. They are in a good position t identify those that might be at risk of developing pressure ulcers and complications of the condition, thus can offer timely advice on prevention and management. Pharmacies in England are commissioned to provide appliance use reviews (AUR) to help increase patients' knowledge and use of appliances, including dressing. AURs involve: "*Establishing the way the patient uses the appliance and the patient's experience of such use;* *Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient;* *Advising the patient on the safe and appropriate storage of the appliance; and* *Advising the patient on the safe and proper disposa of the appliances that are used or unwanted."* *Reference* *Pharmaceutical Services Negotiating Committee: http://psnc.org.uk/services-commissioning/advance* Services/aurs (accessed 03/01/14)	Thank you for your comment.

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148	SH	Royal Pharmaceutical Society	3	FULL	16.1	377	Pharmacists, as experts in medicines, are well placed to offer advice on the prevention and management of pressure ulcers. The draft guidance states the prevention, assessment and management of pressure ulcers requires a comprehensive, multidisciplinary approach, thus we suggest that pharmacist are also included in the list of healthcare professionals who should receive appropriate training and education.	Thank you for your comment. The section to which you are referring is an introductory section and the healthcare professionals provided are listed as examples only. Recommendations 1.3.2 and 1.3.3 are relevant to all healthcare professionals and all healthcare professionals who have contact with anyone at high risk of developing a pressure ulcer and this may include pharmacists.
204	SH	Royal College of Nursing	22	FULL	16.3	384	The term 'healthcare professional' should be defined earlier on in this section to include social care staff (in the community much of the hands on care is delivered by this staff group and as such it is important they receive education and training with regard to pressure ulcers). This message could be lost in the depth of the narrative in this section. Perhaps it could read healthcare professionals and social care staff?	Thank you for your comment. The guideline is applicable to all settings in which NHS care or commissioned care is provided and would be relevant to all staff within these settings.
238	SH	Tissue Viability Society	34	FULL	16.3	384	The term healthcare professional should be defined earlier on in this section to include social care staff (in the community much of the hands on care is delivered by this staff group and as such it is	Thank you for your comment. The guideline is applicable to all settings in which NHS care or commissioned care is provided and would be

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							important they receive education with regard to pressure ulcers.) this message could be lost in the depth of the narrative in this section. Perhaps it could read healthcare professionals and social care staff? Social care staff do provide direct clinical care	relevant to all staff within these settings.
234	SH	Tissue Viability Society	30	FULL	18.2.1	302	Intensive care There was no clinical benefit of alternating pressure or constant low pressure mattresses for the prevention of pressure ulcers in people in intensive care. The GDG considered that for these individuals, a high specification foam mattress, provided on admission to intensive care, should be given as a minimum. This recommendation is of concern to the Tissue Viability Society. Current standard practice in ICU is the provision of dynamic systems as standard care, despite the lack of RCT evidence. The evidence available is largely deemed of low quality. It poses a major problem, whereby current clinical consensus and practice for 20 years and the evidence based guideline (based upon RCT evidence) are at odds. In other areas of healthcare where practice was 'stopped' eg D&C in gynae surgery, this was on the basis of high quality RCT evidence. Is it appropriate to 'down grade' standard care without high level evidence, against a backdrop of strong clinical consensus and low risk of harm in continuing with current practice. This particular guidance could go one of 2 ways.	Thank you for your comment. We look at the highest level of evidence available to answer the review questions, which in this instance, is considered to be randomised control trials. However, we use GRADE methodology to appraise the quality of each study. The GRADE appraisal system takes into account all risk of bias in a study. A fully powered trial will be more likely to show narrow confidence intervals and therefore results will be less likely to be downgraded on imprecision. However if there is other risk of bias in the study then they will be downgraded accordingly. We present this evidence to the GDG, a multidisciplinary group who reach a consensus decision and make the recommendation. Therefore I am afraid we would not seek further consultation of clinicians and managers.

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							You could have financially conscious managers removing dynamic mattresses from ITU and therefore HDU and any other high dependant step down units because guidance says its not needed. That is, managers over riding clinical judgement, or they will ignore because they don't trust it. They may also extend this to if its not needed in ITU then they aren't needed anywhere. And whilst I appreciate we don't yet know the answer to this question and maybe the PRESSURE 2 trial will be deemed of high quality enough to provide conclusive guidance. Perhaps support for this recommendation could be tested with further consultation of clinicians and managers?	We feel that the recommendation is not at odds with clinical practice as you point out we have stated 'a high specification foam mattress, provided on admission to intensive care, should be a minimum'. Therefore this allows for other devices to be used above this minimum requirement.
129	SH	APA Parafricta Ltd	2	NICE	General	General	References to 2 papers reviewing the extrinsic factors involved in the aetiology of pressure ulcers in patients in nursing homes and hospitals in Germany – covering a total of over 40,000 patients - were provided to Natalie Boileau [Senior Guidelines Coordinator NICE] by George Sampson on the 6th March 2012. These papers are: **[1] Friction and shear highly associated with pressure ulcers of residents in long-term care – Classification Tree Analysis (CHAID) of Braden items:** Nils A. Lahmann RN BA MSE PhD, Antje Tannen RN MA MPH PhD, Theo Dassen RN PhD and Jan Kottner RN MA PhD: Journal of Evaluation in Clinical Practice **17** (2011) 168–173 **Basis:** 17,666 residents in 234 long-term care facilities participated in 6 annual point prevalence studies that were conducted from 2004 to 2009 throughout Germany.	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.

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							Conclusion: CHAID analyses have shown that all items of the Braden scale are not equally important. For residents in long-term care facilities in Germany, the existence of 'friction and shear' as a potential and especially as a manifest problem has had the strongest association with pressure ulcer prevalence. **[2] Relation between pressure, friction and pressure ulcer categories: A secondary data analysis of hospital patients using CHAID methods:** Nils A Lahmann, Jan Kottner: International Journal of Nursing Studies 48 (201 1) 1487- 1494 **Basis:** 28,299 Adult hospital patients in 161 Hospitals of all specialities and categories throughout Germany. A secondary analysis of data from six German annual hospital pressure point prevalence studies. **Conclusion:** Based on a large sample of patients from multiple centres throughout Germany results indicate that there is a strong relationship between friction forces and superficial skin lesions and between pressure forces and deeper categories III and IV PUs. If such large studies were available to reference and directly submitted we would respectfully ask that: • The impact of the supplied references, as well as other important information (e.g., EPUAP guidelines) are considered *in totalis* as well as their impact on these guidelines • NICE consider whether a further review of literature is required	

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134	SH	APA Parafricta Ltd	7	NICE	General	General	We also request that, given the gravity and importance of the areas not included in the initial review, NICE significantly revise their guideline	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.
135	SH	APA Parafricta Ltd	8	NICE	General	General	We reiterate that friction and shear are important because of their: 1. Proven conceptual importance in Pressure Ulcers 2. Proven in vivo importance in the pathogenesis of Pressure Ulcers 3. Proven reductions (in trials of Parafricta products) of Pressure Ulcers when friction and shear are reduced	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.
136	SH	APA Parafricta Ltd	9	NICE	General	General	Based on point 8's third sub-point, we ask that NICE consider inclusion of friction and shear reduction devices as part of their review.	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.
137	SH	APA Parafricta Ltd	10	NICE	General	General	Based on point 9, we ask that NICE consider recommending specific devices with clinical benefits proven in trials (e.g., Parafricta) within the clinical guidelines.	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer

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								development.
182	SH	British Medical Association, NHS Primary Care Division	1	NICE	General	General	Whilst we recognise that pressure ulcers are an increasing problem and agree that the prevention of pressure ulcers is important, this draft guidance contains some significant gaps. It does not seem to understand how people present at GP surgeries; the suggestion that this assessment is going to be done when "care [is] received at a GP surgery or an accident and emergency department" is clearly impossible. The guidance fails to identify the resources of time and people with appropriate skills required to make the assessments in general practice. It also fails to adequately address the duration of validity of any such assessment. The draft guidance states: "Reassess pressure ulcer risk if there is a change in clinical status (for example, after surgery, on worsening of an underlying condition or with a change in mobility" However, this is often a barely perceptible process in the community. It perhaps needs a definable timescale. It would seem more appropriate for patients with severe co-morbidities likely to be predisposed to pressure ulcers to have this intervention (assessment and advice) to be delivered at appropriate points in the diagnostic cycle, or	Thank you for your comment. However, we disagree. Recommendation 1.1.2 states that all people who have a risk factor should be risk assessed to identify pressure ulcer risk in settings which do not involve admission. The healthcare professional may consider using a validated scale to support clinical judgement as part of this assessment. These individuals are at a significantly increased risk of developing a pressure ulcer. Thus the GDG believes that it is the responsibility of all healthcare professionals to identify and act upon this risk, regardless of setting. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but we are unable to list all instances where reassessment would be required within the community as this would be individual to the patient. It is the responsibility of individual NHS trusts to identify who is responsible for the provision of wheelchair assessment.

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							perhaps in association with appliance provision (e.g. wheelchair) so that there are clear triggers. Responsibility for care planning, documentation, delivery of advice and of assistance (if required) is unlikely to fall into the domain of normal general practice. Clear definition of where that responsibility lies would be desirable.	
15	SH	College of Occupational Therapists	1	NICE	General	General	Inclusion of service user involvement in care planning has a much stronger emphasis in this guideline, and this is to be commended.	Thank you for your comment.
17	SH	College of Occupational Therapists	3	NICE	General	General	The full guidelines are informative from a research perspective.	Thank you for your comment.
95	SH	INNOVATION REHAB LTD	1	NICE	General	General	Consider adding shear as a causative factor for pressure ulcer development/risk beginning in the introduction and referenced as appropriate throughout the remainder of the document.	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.
96	SH	INNOVATION REHAB LTD	2	NICE	General	General	Consider the use of pressure redistribution throughout the document & remove the wording pressure relief.	Thank you for your comment. The term pressure redistribution has been used throughout the document, where applicable.
97	SH	INNOVATION REHAB LTD	3	NICE	General	General	Consider adding "multiple comorbidities" to risk factors where pressure ulcer risk factors are mentioned throughout the document.	Thank you for your comment. The list of risk factors provided throughout the document are provided as examples and are not intended to be exhaustive.
98	SH	INNOVATION REHAB LTD	4	NICE	General	Gener	In accordance with national and international references, a repositioning schedule of every	Thank you for your comment. Two hourly repositioning was not found to

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						al	2-4 hours is a more common standard except in situations where patient condition dictates a specific repositioning need.	be cost-effective when compared to 4 and 6 hours. The recommendation regarding frequency of repositioning is recommending 4 hours as the minimum frequency, and therefore we have worded the recommendation to state 'at least every 4 hours'. This frequency should be adapted to the needs of the individual.
99	SH	INNOVATION REHAB LTD	5	NICE	General	General	Recommend use of a validated risk assessment tool on all patients initially evaluated at risk or elevated risk as referenced within the NICE Guideline.	Thank you for your comment. Insufficient evidence was identified to recommend the use of a validated risk assessment tool for all patients. However, the GDG acknowledged that there were some benefits to using a validated risk assessment tool and therefore chose to develop recommendation 1.1.3 to consider using these tools. Further detail on how this recommendation was developed can be found in the 'Linking evidence to recommendation' section 7.2.1.
1	NICE	Public Involvement Programme	1	NICE	General	General	Thank you for this opportunity to comment on the draft guideline. Our comments are mainly suggesting where we feel it would be helpful to mention carers and parents explicitly in the recommendations	Thank you for your comment. Please see our responses to individual comments.
128	SH	APA Parafricta Ltd	1	NICE	General	General	As a guide to preventing pressure ulcers the NICE version [which I assume will be the one read by clinicians] contains only one reference to friction or shear, which has been clearly identified as a causative factor in pressure ulcers.	Thank you for your comment. Looking at the causative factors of pressure ulcers was outside of the scope of the current guideline. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer

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131	SH	APA Parafricta Ltd	4	NICE & FULL	General 1: line 3 to 6	General 10	There is no reference in the Full or NICE versions to the guidance published by EPUAP, or their sister organisation in the USA, NPUAP. The European Pressure Ulcer Advisory Panel/National Pressure Ulcer Advisory Panel (EPUAP/NPUAP) 2009 guidance states "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in **combination with** shear."	Thank you for your comment. We have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development. Following discussion on the topics to be included in the guideline, the GDG decided to focus upon the effectiveness of pressure redistributing devices on pressure ulcer prevention. The GDG have prioritised the effectiveness of pressure redistributing devices because the decision was made that, due to the number of devices available, we would look at reducing pressure as the primary cause of pressure ulcers, rather than friction and shear. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.
100	SH	INNOVATION REHAB LTD	6	NICE	General	General	Consider including or creating general recommendations for healthy skin care maintenance and/or hygiene in "Patient and carer" as well as "Healthcare professional training and education" sections.	Thank you for your comment. Recommendations for healthy skin care are outside the scope of the current guideline.

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163	SH	Nottinghamshire Healthcare NHS Trust	9	NICE	General	General	I note that the authors of the document are based predominantly within the acute hospital setting and this is reflected in the document. The majority of healthcare is delivered within the primary healthcare setting however the guideline is significantly biased towards secondary care. Missed opportunity for all work done in Midlands and east, SSKIN bundles and guidance etc	Thank you for your comment. Membership of the Guideline Development Group is taken from across different NHS settings, including community and acute care. Recommendations throughout the guideline are applicable to all care settings. During the scoping phase, three attempts were made to recruit individuals from primary care to join the Guideline Development Group, however, these were unsuccessful. It was outside the scope of the guideline to review evidence relating to existing care bundles.
70	SH	SCA Hygiene Products UK Ltd	1	NICE	General	General	SCA welcomes the opportunity to respond to NICE's draft clinical practice guideline on the prevention and management of pressure ulcers. We have worked within the social care sector in the UK for almost half a century, supporting best-practice routines that promote continence among individuals receiving care. Continence care and the provision of high quality products have been shown to reduce early skin problems, which can lead to pressure ulcers.[i]	Thank you for your comment.
164	SH	Oxford University Hospitals NHS Trust (formerly-Oxford Radcliffe NHS Trust and Nuffield Orthopaedic Centre NHS	1	NICE	Intro	3	" it is hoped that this evidence-based guidance will contribute to reducing the number of pressure ulcers nationally." – Can this be made to say Avoidable pressure ulcers?	Thank you for your comment. However, we disagree and believe that the guideline aims to prevent the total number of pressure ulcers.

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		Trust						
138	SH	APA Parafricta Ltd	11	NICE	Introduction	3	We note you state "Also use of equipment such as seating or beds, which are not designed to provide pressure relief, can cause pressure ulcers." Do you mean "Also use of equipment such as seating or beds, which are not specifically designed to reduce the risk of pressure ulcers, can predispose to pressure ulcers in at-risk individuals."?	Thank you for your comment. We have amended the statement to highlight that devices which are not 'specifically' designed to reduce the risk of pressure ulcers may cause pressure ulcers.
139	SH	APA Parafricta Ltd	12	NICE	Introduction	3	We note you state "pressure ulcers can arise in a number of ways". Pressure ulcers have quite a well-defined pathogenetic mechanism that we ask you explicitly refer to (see EPUAP guidelines above)	Thank you for your comment. The sentence to which you refer is in the general guideline introduction and is not based upon a review of the evidence. The introduction aims to reflect the range of clinical scenarios in which a pressure ulcer may develop and therefore, we have not amended this sentence.
140	SH	APA Parafricta Ltd	13	NICE	Key Priorities for Implementation	7	We implore NICE to be more specific about the at-risk categories of patients to prevent ambiguity. I would also be supportive of guidelines which recommend pressure ulcer risk assessment on admission to secondary care and care homes due to the high numbers of high-profile cases of severe pressure ulcers per year.	Thank you for your comment. Recommendation 1.1.1 – 1.1.4 recommend carrying out a risk assessment for people on admission to secondary care or a care home or for those with a risk factor in other care settings. Unfortunately, due to the limited evidence available to allow the GDG to recommend the use of a specific risk assessment tool, it was not possible to provide a more specific definition of how to identify people who are at risk of development a pressure ulcer. The GDG therefore

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								used consensus to develop the definitions included in Chapter 6 of the full prevention guideline.
141	SH	APA Parafricta Ltd	14	NICE	Key Priorities for Implementation	8	We ask you strongly consider separate sections for 1. Pressure reduction 2. Friction and shear reduction, for each patient sub-category. We should also advocate for assessment of elevated risk in anyone over 65 with complex care needs (i.e. unable to take care of own ADLs)	Thank you for your comment. We have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development. Following discussion on the topics to be included in the guideline, the GDG decided to focus upon the effectiveness of pressure redistributing devices on pressure ulcer prevention. The GDG have prioritised the effectiveness of pressure redistributing devices because the decision was made that, due to the number of devices available, we would look at reducing pressure as the primary cause of pressure ulcers, rather than friction and shear. However, we have highlighted in the introduction of the full guideline the potential role of shear and friction to pressure ulcer development.
2	NICE	Public Involvement Programme	2	NICE	General	10	Section 1. Is there a rationale for choosing age 13 and up for 'young people? Those age 14-16 are considered able to make decisions for themselves in certain circumstances, we are wondering what is	Thank you for your comment. The GDG chose to use the cut off of 13 years for 'young people' as this is in line with other NICE guidance.

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							the rationale for age 13?	
71	SH	SCA Hygiene Products UK Ltd	2	NICE	1.1.1	10	We fully support the recommendation that all adults should be given an assessment of pressure ulcer risk on admission to secondary care or a care home. Pressure ulcers are largely preventable and prompt action will help to reduce incidence.	Thank you for your comment.
72	SH	SCA Hygiene Products UK Ltd	3	NICE	1.1.2	10	We strongly recommend that incontinence should be added to the list of risk factors for developing pressure ulcers. This would ensure that individuals living with incontinence are given an assessment of pressure ulcer risk on receiving NHS care which does not involve admission to secondary care or a care home. Incontinence is a significant risk factor for developing pressure ulcers. Exposure to faeces and urine, combined with constant washing, can reduce the body's natural oils by drying the skin, increasing the risk of damage. Prolonged wetness to the skin increases the risk of pressure sore formation as it makes the fragile skin even more sensitive to friction or shear. Friction injuries may occur when overhydrated skin interacts with incontinence pads, clothing, or the surface of a bed or chair. In most cases, this erosion remains superficial, but it may involve large areas of perineal skin. Shearing may occur when an immobile, incontinent individual is repositioned in a bed or chair, creating vessel damage in the dermis that contributes to pressure injury or ulceration.	Thank you for your comment. The risk factors provided are given as examples only and are not intended to be an exhaustive list.
101	SH	Staffordshire & Stoke-on-Trent Partnership Trust	1	NICE	1.1.2	10	Not clear about what significantly limited mobility means nears clearer	Thank you for your comment. The GDG believe that healthcare professionals are likely to be in a position to judge when limited mobility

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								has an impact upon pressure ulcer risk.
157	SH	Nottinghamshire Healthcare NHS Trust	3	NICE	1.1.2	10	Difficult to identify if patient is at high risk of pressure ulcer without completing risk assessment – very vague recommendation. Doesn't indicate which professional should perform risk assessment, should be all eg nurses, physios OT's in certain areas	Thank you for your comment. The recommendation states that individuals receiving NHS care which does not involve admission to secondary care should receive a risk assessment if they have a risk factor, which healthcare professionals should be able to identify. All healthcare professionals are responsible for conducting a risk assessment and the individual responsible for this will vary across settings and clinical scenarios.
73	SH	SCA Hygiene Products UK Ltd	4	NICE	1.1.5	11	As outlined above, individuals living with incontinence are more vulnerable to developing pressure ulcers. Therefore we advise that, in addition to those adults identified as being at elevated risk of developing a pressure ulcer, a skin assessment by a trained healthcare professional should be given to individuals living with incontinence.	Thank you for your comment. The risk factors provided are given as examples only and are not intended to be an exhaustive list. The healthcare professional would give an assessment of pressure ulcer risk, taking into consideration such factors and those considered to be at high risk would be given a formal skin assessment.
149	SH	British Association of Dermatologists	1	NICE	1.1.5	11	The document identity a skin assessment, which includes looking for 'dry or inflamed skin', by a trained healthcare professional as a key priority for implementation of the guideline. We do not think it would be useful for dermatologists to do this skin assessment, but in certain cases in the presence of dermatological disease, the guideline should recommend a dermatology review.	Thank you for your comment. Recommendation 1.1.5 does not provide information on who is responsible for carrying out a skin assessment. It is likely that the healthcare professional for responsibility for conducting this assessment would vary between care settings and clinical scenarios. It is outside the scope of the guideline

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								to review the evidence relating to dermatological assessment.
158	SH	Nottinghamshire Healthcare NHS Trust	4	NICE	1.1.7	11	Consider repeating skin assessment every 2 hours for adults with non-blanching erythema – not practicable within a community setting. Also again, who should perform skin assessment. Teach carers etc	Thank you for your comment. However, the GDG felt that an individual with non-blanchable erythema should receive regular skin assessment in all settings to ensure that pressure ulcer development is prevented. However, we have amended the recommendation to highlight the importance of initiating appropriate preventative action in adults who have non-blanching erythema and that in these individuals, healthcare professionals should consider repeating the skin assessment at least every 2 hours until resolved. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.
102	SH	Staffordshire & Stoke-on-Trent Partnership Trust	2	NICE	1.1.7	11	Skin assessments for patients who have non blanching erythema every 2 hours is not feasible in the community setting	Thank you for your comment. However, the GDG felt that an individual with non-blanchable erythema should receive regular skin assessment in all settings to ensure that pressure ulcer development is prevented. However, we have amended the recommendation to highlight the importance of initiating appropriate preventative action in

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								adults who have non-blanching erythema and that in these individuals, healthcare professionals should consider repeating the skin assessment at least every 2 hours until resolved. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.
165	SH	Oxford University Hospitals NHS Trust (formerly-Oxford Radcliffe NHS Trust and Nuffield Orthopaedic Centre NHS Trust	2	NICE	1.1.7	11	Consider repeating skin assessment at least every 2 hours – For how long as Non blanching erythema may last for days.	Thank you for your comment. We have amended recommendation 1.1.7 to highlight that skin assessment should be repeated at this frequency until non blanching erythema is resolved.
74	SH	SCA Hygiene Products UK Ltd	5	NICE	1.1.8	12	As outlined above, we advise that in addition to those adults identified as being at elevated risk of developing a pressure ulcer, an individualised care plan should be developed for individuals living with incontinence.	Thank you for your comment. The risk factors provided are given as examples only and are not intended to be an exhaustive list. The healthcare professional would give an assessment of pressure ulcer risk, taking into consideration such factors and those considered to be at high risk would be given a formal skin assessment.
75	SH	SCA Hygiene	6	NICE	1.1.8	13	We support the inclusion of incontinence in the	Thank you for your comment.

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		Products UK Ltd					recommendation that consideration should be given to using a barrier preparation in adults who are at risk of developing a moisture lesion. Individuals with incontinence are particularly vulnerable to developing moisture lesions due to the skin's on-going exposure to moisture and contact with urine and faeces.	
155	SH	Nottinghamshire Healthcare NHS Trust	1	NICE	1.1.8	8	Concerned that adults at risk should be repositioned at a minimum of 6 hours – this seems a long time – also that staff should help to reposition if unable to do so independently – This cannot always be achieved in community settings.	Thank you for your comment. Two hourly repositioning was not found to be cost-effective when compared to 4 and 6 hours. The recommendation regarding frequency of repositioning is recommending 4 hours as the minimum frequency, and therefore we have worded the recommendation to state 'at least every 4 hours'. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.
21	SH	College of Occupational Therapists	7	NICE	1.1.9	12	There are a small percentage of individuals with severe contractures and fixed distorted body shapes who can't be repositioned or who won't tolerate repositioning.	Thank you for your comment. We acknowledge that there are some individuals who are unable to tolerate repositioning. Recommendations 1.1.8 and 1.1.9 highlight that appropriate equipment may be used to aid repositioning if needed.
159	SH	Nottinghamshire Healthcare NHS Trust	5	NICE	1.1.9	12	Patients felt to be at risk to be repositioned 6 hourly ? too long an interval – also unable to assist at every position change in community setting. Missed opportunity for SSKIN bundle	Thank you for your comment. The recommendation regarding frequency of repositioning is recommending 6 hours as the minimum frequency, and

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								therefore we have worded the recommendation to state 'at least every 6 hours' to allow more frequent repositioning where required. This was also informed by the economic model (see Appendix L) which found that more frequent repositioning at alternative intervals of 2 and 4 hours was not cost-effective compared to repositioning every 4 hours. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented. It was outside the scope of the guideline to review evidence relating to existing care bundles.
4	NICE	Public Involvement Programme	4	NICE	1.1.9-10	12	Should this recommendation include support for family or other unpaid carers to help the person to re-position? (or a cross reference to Rec 1.3.1)	Thank you for your comment. However, it was outside the scope of the review question to identify evidence on the effectiveness of providing support for family and carers.
150	SH	British Association of Dermatologists	2	NICE	1.1.9 and 1.1.10	12	It is not clear on what the difference is between an adult who has been assessed as being at risk, and an adult who is at elevated risk of developing a pressure ulcer. (*This also applies to 1.2.4 and 1.2.6 and to 1.2.5 and 1.2.7.*) The wording would be clearer if 1.1.10 was written as, "Encourage adults, who have been assessed as being at elevated risk of developing..." – the same applies to 1.2.6 and	Thank you for your comment. We agree that recommendations 1.2.8, 1.2.9, 1.1.8 and 1.1.9 would be clearer as suggested and have amended this is line with your comment. As there was insufficient evidence

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							1.2.7. It would be better stated as moderate and high risk.	identified to allow the GDG to recommend the use of a specific risk assessment tool, the terms 'at risk' and 'at high risk' were chosen to avoid confusion and ensure that there was no relation to a threshold used within a specific risk assessment tool.
180	SH	British Healthcare Trades Association	2	NICE	1.1.14	13	Two points appear to be overlooked in the consultation document: 1. Pressure care management should not only be applied to those using mattresses but also seating where continued care on preventative measures are also needed to ensure the best possible patient outcome. 2. A range of international standards has been developed/are under development which impact upon clinical decision making in relation to product characteristics and performance relating to seating. Mattress standards are also under development which bear a relationship to those below, in particular ISO 16840 part 6: ISO ISO 1684-2 Wheelchair seating -- Part 2: Determination of physical and mechanical characteristics of devices intended to manage tissue integrity -- Seat cushions ISO 16840-9 Clinical interface pressure mapping guidelines for seating ISO 16840-6	Thank you for your comments. We agree that all equipment and devices purchased should meet international standards. It is the responsibility of purchasers to judge whether the equipment is in line with these regulations.

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							Wheelchair seating -- Part 6: Stability of properties with use ISO16840-7 Wheelchair seating - Part 7: Heat and Water Vapour Testing (Insensible Moisture) ISO 16840-11 Wheelchair seating -- Part 11: Determination of dissipation characteristics of sensible perspiration into seat cushions ISO 16840-12 Wheelchair Seating - Part 12: Apparatus and Method for Cushion Envelopment Testing	
18	SH	College of Occupational Therapists	4	NICE	1.1.17	13	Considering using a pressure relieving cushion for adults who use a wheelchair is insufficient from a clinical perspective. The use of pressure relieving cushions would be strongly recommended in clinical practice for individuals at elevated risk of pressure ulcers such as people with spinal cord injury, multiple sclerosis and6 traumatic brain injury.	Thank you for your comment. As per the NICE Guidelines manual 2012 http://publications.nice.org.uk/the-guidelines-manual-pmg6, the wording of a recommendation reflects the strength of the evidence supporting it. Unfortunately, insufficient evidence was identified to allow the GDG to develop a stronger recommendation.
166	SH	Oxford University Hospitals NHS Trust (formerly-Oxford Radcliffe NHS Trust and Nuffield Orthopaedic Centre NHS Trust	3	NICE	1.1.17	General	There do not appear to be any recommendations for patients sitting out in chairs other than wheelchairs on product or time.	Thank you for your comment. The GDG agree and recommendation 1.1.16 has been revised to highlight that the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time should be considered.

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160	SH	Nottinghamshire Healthcare NHS Trust	6	NICE	1.1.18	13	Concerned re use of barrier cream for oedema dry or inflamed skin – shouldn't this be a moisturising cream? Careful use of barrier creams needed	Thank you for your comment, however this has not been amended. We have used the term barrier preparations throughout and this was intended to encompass moisturising creams.
156	SH	Nottinghamshire Healthcare NHS Trust	2	NICE	1.2.1	9	Risk assessment for children – not clear if this for all children known to paediatric teams – again difficult to achieve in community settings	Thank you for your comment. Recommendation 1.2.1 has been clarified to highlight that all children with a risk factor, receiving NHS care, including those within the community should be assessed for pressure ulcer risk. Recommendation 1.2.2 has been developed to suggest that all children being admitted to secondary or tertiary care should be assessed for pressure ulcer risk. The GDG acknowledge that there may be some challenges in implementing this recommendation in the community but feel that provision should be put in place to allow this to be implemented.
161	SH	Nottinghamshire Healthcare NHS Trust	7	NICE	1.2.1	14	Is this for all children??	Thank you for your comment. Recommendation 1.2.1 has been clarified to highlight that all children with a risk factor, receiving NHS care, including those within the community should be assessed for pressure ulcer risk. Recommendation 1.2.2 has been developed to suggest that all children being admitted to secondary or tertiary care should be assessed for

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								pressure ulcer risk.
5	NICE	Public Involvement Programme	5	NICE	1.2.10	15	This Rec suggests that parents and carers should understand the reasons for re-positioning, but there appear to be no recommendation to ensure they are offered appropriate support and training to facilitate this. Might this be added? (or a cross reference to 1.3.1?)	Thank you for your comment. However, it was outside the scope of the review question to identify evidence on the effectiveness of providing support for family and carers.
6	NICE	Public Involvement Programme	6	NICE	1.2.18	16	Please can the discussion include 'parents and carers where appropriate'?	Thank you for your comment. This recommendation, and other relevant recommendations, have been amended as per your suggestion.
19	SH	College of Occupational Therapists	5	NICE	1.2.19	16	Our comment is that, as children who are long-term wheelchair users get regular wheelchair reviews, a similar service should be provided for adults as these children will become adults. Increasing age further increases the risk of pressure ulcers.	Thank you for your comment. The recommendations relating to neonates, infants, children and young people were developed using a Delphi consensus methodology. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults. The GDG have added recommendation 1.1.16 to cover the needs of people when sitting 'Consider the seating needs of people at risk of developing a pressure ulcer who are sitting for prolonged periods of time' and added to recommendation 1.1.17 to include these individuals ('Consider a high-specification foam or equivalent pressure redistributing cushion for

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								adults who use a wheelchair or who sit for prolonged periods.').
151	SH	British Association of Dermatologists	3	NICE	1.2.9	15	This also applies to adults but is not stated.	Thank you for your comment. The recommendations relating to neonates, infants, children and young people were developed using a Delphi consensus methodology. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults.
76	SH	SCA Hygiene Products UK Ltd	7	NICE	1.3.1	17	As outlined above, we advise that in addition to those adults identified as being at elevated risk, individuals living with incontinence should be given information about pressure ulcers by healthcare professionals.	Thank you for your comment. Recommendation 1.3.2 (1.3.1 in the draft version of the guideline) outlines that information that will be provided to individuals at high risk of developing a pressure ulcer. Page 11 of the NICE guideline provides a definition of who would be considered to be at high risk of developing a pressure ulcer. Some individuals living with incontinence may be considered to be at high risk of developing a pressure ulcer and where appropriate, should therefore be provided with information about pressure ulcers. However, the GDG did not consider that all individuals living with incontinence would be at high risk of developing a pressure ulcer and these have not been added as an example of a high risk population.

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77	SH	SCA Hygiene Products UK Ltd	8	NICE	1.3.2	18	As outlined above, we advise that in addition to those adults identified as being at elevated risk, the individual needs of those with incontinence should be taken into account when supplying information about pressure ulcers.	Thank you for your comment. Recommendation 1.3.2 (1.3.1 in the draft version of the guideline) outlines that information that will be provided to individuals at high risk of developing a pressure ulcer. Page 11 of the NICE guideline provides a definition of who would be considered to be at high risk of developing a pressure ulcer. Some individuals living with incontinence may be considered to be at high risk of developing a pressure ulcer and where appropriate, should therefore be provided with information about pressure ulcers. However, the GDG did not consider that all individuals living with incontinence would be at high risk of developing a pressure ulcer and these have not been added as an example of a high risk population.
78	SH	SCA Hygiene Products UK Ltd	9	NICE	1.3.3	18	We strongly support the recommendation that training should be provided to healthcare professionals on preventing a pressure ulcer. Management of continence and keeping individuals clean and dry is essential in preventing skin damage that can lead to pressure ulcers. A study in Kettering found that a programme of change focusing on continence care helped reduce the incidence of skin damage on medical wards by 80 per cent. Improved access to a better range of incontinence management products, along with	Thank you for your comment.

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							education on their selection and correct use, made a significant impact. Impact costs were identified in terms of reductions in the incidence of moisture lesions extrapolated over one year and savings made on the products used. For every £1 spent, Kettering General Hospital NHS Foundation Trust generates £3.84 of benefits over a year. This calculation does not take into account the additional quality benefits for patients that have not been monetised.[ii]	
16	SH	College of Occupational Therapists	2	NICE	1.3.3 & 1.3.4	18	The focus on education is beneficial.	Thank you for your comment.
115	SH	James Lind Alliance Pressure Ulcer Partnership	1	NICE	1.4 Key research recommendations	Pages 26 to 28	We note the key research recommendations identified at pages 26 to 28 in the NICE version of the draft document "*Pressure Ulcers: Prevention and management of Pressure Ulcers, NICE Guideline – Draft for Consultation" November 2013.* We would wish to draw to your attention the process and outcomes of the recent that the James Lind Alliance Pressure Ulcer Priority Setting Partnership which has recently identified research priorities for the prevention and treatment of pressure ulcers. Our top 12 research recommendations are submitted for your attention and we strongly urge you to reflect these priorities in your final document. <u>Background</u> The James Lind Alliance Pressure Ulcer Priority Setting Partnership is a partnership of patients,	Thank you for your comment and for highlighting the James Lind Alliance Pressure Ulcer Priority Setting Partnership. In accordance with the NICE guidelines manual 2012 http://publications.nice.org.uk/the-guidelines-manual-pmg6 , the GDG have developed and prioritised their own research recommendations for future research, based upon the results of the evidence reviews conducted during guideline development. We hope that the research recommendation developed by the Guideline Development Group will complement those of the James Lind Alliance.

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							carers and clinicians which was formed to identify research priorities in the prevention and management of pressure ulcers. In 2012 and 2013 we asked patients, carers and healthcare professionals where they would like to see further research or where they thought there was uncertainty about the best medical and nursing care of people with, or at risk of, pressure ulcers. We gathered nearly 1,000 questions about pressure ulcer prevention and treatment. We sorted and categorised these questions and checked to see where existing research already provides a reliable and complete answer. All questions without complete and reliable evidence were submitted to the UK Database of Uncertainties about the Effects of Treatments (UK DUETs) and can be found at http://www.library.nhs.uk/duets/SearchResults.aspx?tabID=294&catID=15594 We then asked patients, carers and health professionals to rate the most important questions for further research. Finally patients, carers and health professionals came together in March 2013 to choose their top pressure ulcer prevention and treatment research questions from a shortlist of 30 of the most popular questions. A full day of debate, discussion and hard choices in workshop groups and a final plenary session led to the selection and ranking of the Top 12.	

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							Further information about the JLAPUP can be found at www.jlapressureulcerpartnership.co.uk. <u>JLAPUP Top 12 Research Priorities</u> 1. How effective is repositioning in the prevention of pressure ulcers? 2. How effective at preventing pressure ulcers is involving patients, family and lay carers in patient care? 3. Does the education of health and social care staff on prevention lead to a reduction in the incidence of pressure ulcers and, if so, which are the most effective education programmes (at organisational and Health/Social Care level)? 4. What is the relative effectiveness of the different types of pressure relieving beds, mattresses, overlays, heel protectors and cushions (including cushions for electric and self-propelling wheelchairs) in preventing pressure ulcers? 5. What impact do different service models have on the incidence of pressure ulcers including staffing levels, continuity of care [an on-going relationship with same staff members] and the current organisation of nursing care in hospitals? 6. What are the best service models (and are they sufficiently accessible) to ensure that patients with pressure ulcers receive the best treatment outcomes (including whether getting people with pressure ulcers and their carers more involved in their own pressure ulcer management improves ulcer healing and if so, the most effective models of engagement)? 7. For wheelchair users sitting on a pressure ulcer,	

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							how effective is bed rest in promoting pressure ulcer healing? 8. How effective are wound dressings in the promotion of pressure ulcer healing? 9. Does regular turning of patients in bed promote healing of pressure ulcers? 10. Does improving diet (eating) and hydration (drinking) promote pressure ulcer healing? 11. How effective are surgical operations to close pressure ulcers? 12. How effective are topical skin care products and skin care regimes at preventing pressure ulcers? A full detailed breakdown of the Top 12 in PICO detail and further information can be provided on request.	
116	SH	ACTIVA HEALTHCARE	1	NICE	1.4.14	20	A new EWMA Document: Debridement (2013) states that autolytic debridement was positioned as the simplest method of debridement but there are a number of disadvantages of this method. Newer simple methods such as modern mechanical debridement (e.g. monofilament fibre pad) are the least time consuming and need to be considered as they are widely available.	Thank you for your comment. NICE are currently developing a NICE Medical Technology Evaluation Programme guideline on 'Debrisoft monofilament debridement pad for use in acute or chronic wounds'. This guideline has not considered the use of this device. **We have included a cross reference to this guidance in the section 'Related guidance'.**
117	SH	ACTIVA HEALTHCARE	2	NICE	1.4.14	20	A recent small study has highlighted the difficulties in accurate categorisation of pressure ulcers. Assessment can be facilitated by rapid, bedside debridement using a monofilament fibre pad (Dowsett, Swan & Orig, 2013).	Thank you for your comment. NICE are currently developing a NICE Medical Technology Evaluation Programme (MTEP) guideline on 'Debrisoft monofilament debridement pad for use in acute or chronic

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								wounds'. This guideline has not considered the use of this device. We have included a cross reference to this guidance in the section 'Related guidance'.
118	SH	ACTIVA HEALTHCARE	3	NICE	1.4.14	20	Debrisoft is currently under consideration by NICE (Ref: EP129) as an effective method of debridement for use in acute and chronic wounds, which includes pressure ulcers. It is being considered as a method of reducing nurse visits and debridement time compared with other methods.	Thank you for your comment. NICE are currently developing a NICE Medical Technology Evaluation Programme (MTEP) guideline on 'Debrisoft monofilament debridement pad for use in acute or chronic wounds'. This guideline has not considered the use of this device. We have included a cross reference to this guidance in the section 'Related guidance'.
152	SH	British Association of Dermatologists	4	NICE	1.4.18	21	This recommendation is given for adults but not stated for the paediatric population. There is a lack of evidence in both populations but it would be considered appropriate to state it for the paediatric population too.	Thank you for your comment. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that some of the principles of the recommendations developed for adults may be applicable to. neonates, infants, children and young people
153	SH	British Association of Dermatologists	5	NICE	1.4.20 and 1.5.21	21 and 25	In point 1.5.21 it states: "Consider topical antimicrobial dressings to treat a pressure ulcer where clinically indicated in neonates, infants, children and young people, for example, where there is spreading cellulitis". There is no mention of the use of topical antimicrobial dressings in the adult population.	As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that some of the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults.
8	NICE	Public Involvement	8	NICE	1.4.21	21	Might a carer – where appropriate – be involved in a discussion about dressings?	Thank you for your comment. This recommendation, and other relevant

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		Programme						recommendations, have been amended as per your suggestion.
9	NICE	Public Involvement Programme	9	NICE	1.4.24	22	Might a carer be involved (where appropriate) in a discussion about how to avoid heel ulcers?	Thank you for your comment. This recommendation, and other relevant recommendations, have been amended as per your suggestion.
7	NICE	Public Involvement Programme	7	NICE	1.4.6	19	Please could this information also be offered to family and carers, where appropriate?	Thank you for your comment. This recommendation, and other relevant recommendations, have been amended as per your suggestion.
179	SH	British Healthcare Trades Association	1	NICE	1.4.9	20	This is very brief and should include more comment as provided in section 1.5.10 and 1.5.12 of the neonate, infants……..	Thank you for your comment. The recommendations relating to neonates, infants, children and young people were developed using a Delphi consensus methodology. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults.
20	SH	College of Occupational Therapists	6	NICE	1.4.9	20	This is nothing in this section on cushions or techniques for repositioning in sitting, even though individuals can be at more risk of developing pressure ulcers in sitting than in lying.	Thank you for your comment. The GDG agree and have added recommendation 1.1.16 to cover the needs of people when sitting and revised recommendation 1.1.17 to include these individuals.
162	SH	Nottinghamshire Healthcare NHS Trust	8	NICE	1.4.9	20	Use of high spec mattress versus dynamic system – this is a little vague	Thank you for your comment. There was very little evidence for each type of high specification foam mattress and dynamic support surface therefore it was not possible to identify

ID	Type	Stakeholder	Order No	Document	Section No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
								which particular types were more effective or recommend a specific type of device.
103	SH	Staffordshire & Stoke-on-Trent Partnership Trust	3	NICE	1.4.9	20	Definition of a high specification mattress would be beneficial	Thank you for your comment. A definition of 'high specification foam mattress' is included in the glossary of the full guidelines.
154	SH	British Association of Dermatologists	6	NICE	1.5.10	23	"Consider using specialist support surfaces (including dynamic support surfaces where appropriate) for neonates, infants and children and young people" – does this also apply to adults (it only recommends the use of a high-specification foam mattress and to consider the use of a dynamic support surface)? Recommendation 1.5.10 is based on a modified Delphi consensus technique. The quality of evidence is not great, and there are issues with the definition of a 'standard foam mattress', but there does appear to be a suggestion that other specialist support surfaces may provide some benefit for adults too.	Thank you for your comment. As outlined in section 6.1.4 of the full guideline, healthcare professionals may wish to consider that the principles of the recommendations developed for neonates, infants, children and young people may be applicable to adults.
130	SH	APA Parafricta Ltd	3	NICE	2.4	7	The statement *"Pressure redistributing devices are widely accepted methods of trying to prevent the development of pressure areas for people assessed as being at risk. These devices include different types of mattresses, overlays, cushions and seating. They work by reducing pressure, friction or shearing forces. There is limited evidence on the effectiveness of these devices"* contains 3 incorrect or unclear statements assumptions:, • There is no evidence that these devices have any direct reduction of friction and shear – they only reduce pressure. • The devices reduce pressure on affected areas by redistribution rather than overall	Thank you for your comment. We have highlighted in the relevant text that this is only a possible method of action for these devices and that they may work by reducing or redistributing pressure, friction or shearing forces. We have also amended the statement to acknowledge that the limited evidence identified is often contradictory.

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							reducing pressure • Their evidence is not just limited – it is arguably absent or contradictory in some circumstances	
207	SH	Tissue Viability Society	3	Summary draft guideline	General	General	The summary is not well laid out in terms of clear distinction between practice recommendations - things which should be done and things which should not be done	Thank you for your comment. However, we believe that the guideline is clearer if divided by clinical area.
208	SH	Tissue Viability Society	4	Summary draft guideline	2	26-28	It is not clear why the small number of research recommendations selected for the summary are thought to be more important than other research recommendation.	Thank you for your comment. Research recommendations were developed during the course of guideline development in areas where limited or no evidence was identified to help inform the recommendation. These areas were subsequently prioritised for inclusion in the guideline by the Guideline Development Group. In accordance with the NICE guidelines manual 2012 http://publications.nice.org.uk/the-guidelines-manual-pmg6 , the number of research recommendations included in the NICE guideline is limited to 5 areas. However, the GDG may choose to include additional research recommendations in the full guideline.
209	SH	Tissue Viability Society	5	Summary draft guideline	2.5	28	The use of the term 'repositioning' is somewhat limiting since the main issue for very high risk long-term patients is 'off-loading'. Is the suggested research priority specific to repositioning in bed, or methods/frequency of	Thank you for your comment. The research recommendation is intended to cover the most effective position and frequency of repositioning for individuals at risk of developing a pressure ulcer. This is not intended to

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							patients/carers/hcps relieving pressure areas by repositioning/off-loading?	be specific to repositioning in bed.

These organisations were approached but did not respond:

3M Health Care UK
AbbVie

Aguettant Limited
Aintree University Hospital NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
All Wales Dietetic Advisory Committee
All Wales Senior Nurses Advisory Group
All Wales Tissue Viability Nurse Forum
Allocate Software PLC
Anglesey Local Health Board
Anglian Community Enterprise
ArjoHuntleigh
Ashford and St Peter's Hospitals NHS Trust
Aspen Medical Europe
Association of Anaesthetists of Great Britain and Ireland
Association of British Healthcare Industries
Association of British Insurers
Association of Chartered Physiotherapists in Neurology
Association of Surgeons of Great Britain and Ireland
Associazione Infermieristica per lo Studio delle Lesioni Cutanee
B. Braun Medical Ltd
Barchester Healthcare
Barnsley Hospital NHS Foundation Trust
Basildon and Thurrock University Hospitals NHS Foundation Trust
Baxter Healthcare
Bedfordshire and Hertfordshire Tissue Viability Nurses Forum
BES Rehab Ltd
Betsi Cadwaladr University Health Board

Bradford District Care Trust
Brighton and Sussex University Hospital NHS Trust
Bristol Community Health
British Academy of Childhood Disability

British Association for Parenteral & Enteral Nutrition

British Association of Plastic Reconstructive and Aesthetic Surgeons
British Association of Prosthetists & Orthotists
British Dietetic Association
British Geriatrics Society

British Infection Association
British Medical Journal
British National Formulary
British Nuclear Cardiology Society
British Pain Society
British Psychological Society
British Red Cross
British Society for Antimicrobial Chemotherapy
British Society of Rehabilitation Medicine
BSN Medical
Buckinghamshire Hospitals NHS Trust
Buckinghamshire Primary Care Trust
BUPA Foundation
Calderdale and Huddersfield NHS Trust
Cambridge University Hospitals NHS Foundation Trust
Cambridgeshire & Peterborough Mental Health Trust
Camden Link
Capsulation PPS
Capsulation PPS
Cardiff and Vale University Health Board
Cardiff University
Care Quality Commission (CQC)
Central & North West London NHS Foundation Trust
Central London Community Health Care NHS Trust
Central London Community Health Care NHS Trust
Central Manchester University Hospitals NHS Foundation Trust
Chartered Society of Physiotherapy
Chronic Disease Management Ltd
City Hospitals Sunderland NHS Foundation Trust
Clarity Informatics Ltd
Cochrane Wounds Group
Colchester Hospital University NHS Foundation Trust

Community District Nurses Association
ConvaTec Ltd
Co-operative Pharmacy Association

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Covidien Ltd.
Craegmoor
Critical Care National Network Nurse Lead Forum
Croydon Clinical Commissioning Group
Croydon Health Services NHS Trust
Croydon Primary Care Trust
Croydon University Hospital
Cumbria Partnership NHS Trust
Cytori Therapeutics Inc
Department of Health, Social Services and Public Safety - Northern Ireland
Dermal Laboratories
Dialog Devices
Dorset Healthcare University NHS Foundation Trust
Dorset Primary Care Trust
Dudley Group Of Hospitals NHS Foundation Trust
East and North Hertfordshire NHS Trust
East Kent Hospitals University NHS Foundation Trust
East Midland Ambulance Services NHS
East Midlands Ambulance Service NHS
Epsom & St Helier University Hospitals NHS Trust
Equalities National Council
Ethical Medicines Industry Group
European Pressure Ulcer Advisory Panel
Faculty of Dental Surgery
Faculty of Public Health
First Technicare Ltd
Five Boroughs Partnership NHS Trust

Forest Laboratories UK Ltd
Foundation Trust Network
Frimley Park NHS Foundation Trust
Frontier Therapeutics Limited
Galway University Hospital
George Eliot Hospital NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Golden Jubilee Regional Spinal Cord Injuries Centre
Great Ormond Street Hospital
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hammersmith and Fulham Primary Care Trust
Hampshire Partnership NHS Trust
Hayward Medical Communications

HCAI Research Network
Healing Honey International Ltd
Health & Social Care Information Centre
Health and Care Professions Council
Health Protection Agency
Healthcare Improvement Scotland
Healthcare Infection Society
Healthcare Quality Improvement Partnership
Healthwatch East Sussex
Help the Hospices
Heritage Manor Ltd
Hertfordshire Partnership NHS Foundation Trust
Hertfordshire Partnership NHS Trust
Herts Valleys Clinical Commissioning Group
HFA Healthcare Limited
Hill-Rom
Hindu Council UK
Hockley Medical Practice
Hollister Ltd
Humber NHS Foundation Trust
Huntleigh Healthcare Ltd
Independent Healthcare Advisory Services
Inditherm Medical
Infection Control Nurses Association
Infection Prevention Society
Innovation Rehab
Integrity Care Services Ltd.
Ipswich Hospital NHS Trust
James Cook University Hospital

James Paget University Hospitals NHS Foundation Trust
Johnson & Johnson
Karomed Limited
Kaymed
KCI Europe Holding B.V.
KCI Medical Ltd
Kent Community Health Trust
Kettering General Hospital
Kimal PLC
King's College Hospital NHS Foundation Trust
Kingston Primary Care Trust
Knowsley Primary Care Trust
Lancashire Care NHS Foundation Trust

Leeds Community Healthcare NHS Trust
Leeds South and East Clinical Commissioning Group
Leeds Teaching Hospitals NHS Trust
Leicestershire Partnership NHS Trust

Limbless Association
Liverpool Community Health
Liverpool Primary Care Trust
Local Government Association
London Clinic
Luton and Dunstable Hospital NHS Trust
Maersk Medical Ltd
Maidstone and Tunbridge Wells NHS Trust

Maquet UK Ltd
Marie Curie Cancer Care
MASCIP
Medical Support Systems Limited
Medicines and Healthcare products Regulatory Agency
Medway Community Centre
Medway NHS Foundation Trust
Mid Staffordshire NHS Foundation Trust
Midlands Centre for Spinal Injuries
Ministry of Defence (MOD)
Molnlycke Health Care Ltd
Monash Health
MRSA Action UK
Muscular Dystrophy Campaign
Napp Pharmaceuticals Ltd
National Cancer Action Team
National Care Forum
National Childbirth Trust
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Deaf Children's Society
National Institute for Health Research Health Technology Assessment Programme
National Institute for Health Research
National Nurses Nutrition Group
National Patient Safety Agency
National Public Health Service for Wales
National Spinal Injuries Centre

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NDR UK
Nester Healthcare Group Plc
NHS Barnsley Clinical Commissioning Group
NHS Bassetlaw CCG
NHS Bournemouth and Poole
NHS Clinical Knowledge Summaries
NHS Connecting for Health
NHS Cornwall and Isles Of Scilly
NHS County Durham and Darlington
NHS Cumbria Clinical Commissioning Group
NHS Direct

NHS Halton CCG
NHS Health at Work
NHS Herefordshire
NHS Improvement
NHS Midlands and East
NHS Plus
NHS Sheffield
NHS South Birmingham
NHS South Cheshire CCG
NHS South of England
NHS Wakefield CCG
NHS Warwickshire North CCG
NHS Warwickshire Primary Care Trust
NHS West Essex
Nightingale Care Beds Ltd
Norfolk Community Health and Care NHS Trust
North East London Cancer Network
North East London Community Services
NORTH EAST LONDON FOUNDATION TRUST
North of England Commissioning Support
North of England Critical Care Network
North West London Hospitals NHS Trust
Northampton General Hospital NHS Trust
Northamptonshire Primary Care Trust
Northern Tissue Viability Professional Forum
Northumberland Care Trust
Northumberland, Tyne & Wear NHS Trust
Norwich District Hospital Foot Health Services
Nottingham City Council
Nuffield Health
Nuffield Orthopaedic Centre

Nutricia Clinical Care
OPED UK Ltd
Outlook Care
Oxford University Hospitals NHS Trust
Oxfordshire Clinical Commissioning Group

Parenteral and Enteral Nutrition Group
Patient Assembly
Pegasus Limited
Peninsula Community Health Services
PERIGON Healthcare Ltd
Pfizer
Pharmametrics GmbH
PHE Alcohol and Drugs, Health & Wellbeing Directorate
Pilgrims Hospices in East Kent
POhWER
Poole Hospital NHS Trust
PrescQIPP NHS Programme
Primary Care Pharmacists Association
Primrose Bank Medical Centre
Public Health Wales NHS Trust
PURSUN UK
Queen Elizabeth Hospital King's Lynn NHS Trust
Robert Jones & Agnes Hunt Orthopaedic & District Hospital NHS Trust
ROHO Group, The
Rotherham Primary Care Trust
Royal Berkshire NHS Foundation Trust
Royal Brompton Hospital & Harefield NHS Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Midwives

Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Paediatrics and Child Health , Gastroenetrology, Hepatology and Nutrition
Royal College of Pathologists

Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Free Hospital NHS Foundation Trust

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Royal Liverpool and Broadgreen University Hospitals NHS Trust
Royal National Orthopaedic Hospital NHS Trust
Royal Pharmaceutical Society
Royal Society of Medicine
Royal West Sussex NHS Trust
Salisbury NHS Foundation Trust
Sanctuary Care
Scottish Intercollegiate Guidelines Network
Section of wound healing
Sheffield Childrens Hospital
Sheffield Primary Care Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sky Medical Technology Ltd
Smith & Nephew Healthcare Ltd
SNDRi
Social Care Institute for Excellence
Society for Vascular Technology of Great Britiain and Ireland
Society of Chiropodists & Podiatrists
Solent NHS Trust
South Asian Health Foundation
South Devon Healthcare NHS Foundation Trust
South Essex Partnership NHS Foundation Trust
South London & Maudsley NHS Trust
South London Cardiac and Stroke Network
South Staffordshire Primary Care Trust
South Tyneside NHS Foundation Trust
South West London Elective Orthopaedic Centre
South West Yorkshire Partnership NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
Southend Hospitals NHS Foundation Trust
Southern Alliance of Tissue Viability Nurses
Southern Health Foundation Trust
Southport and Ormskirk Hospital NHS Trust
Spinal Injuries Association
SSL International plc
St Andrews Healthcare
St Mary's Hospital

STM Healthcare
Stockport Clinical Commissioning Group
Stockport NHS Foundation Trust
Sue Ryder
Surgical Dressing Manufacturers Association

Surgical Materials Testing Laboratory
Synidor
Systagenix
Talley Group Ltd
Tameside Hospital NHS Foundation Trust
Tempur-Med
Teva UK
The Association for Perioperative Practice
The Association of the British Pharmaceutical Industry
The National Association of Assistants in Surgical Practice
The Patients Association
The Princess Alexandra Hospital NHS Trust
The Relatives and Residents Association
The Rotherham NHS Foundation Trust
The Walton Centre for Neurology and Neurosurgery

Tomorrow-Options
Torbay and Southern Devon Health and Care NHS Trus

UK Clinical Pharmacy Association
UK Specialised Services Public Health Network
Unison
United Lincolnshire Hospitals NHS
University College London Hospital NHS Foundation Trust
University Hospital Birmingham NHS Foundation Trust
University Hospital of North Staffordshire NHS Trust
University Hospitals Birmingham
Urgo Medical Ltd
W.L. Gore & Associates
Walsall Local Involvement Network
Walsall Teaching Primary Care Trust
Welsh Government
Welsh Wound Network
West Middlesex University Hospital NHS Trust
West Midlands Ambulance Service NHS Trust
West Suffolk Hospital NHS Trust
Western Cheshire Primary Care Trust
Western Sussex Hospitals NHS Trust
Westmeria Healthcare Ltd
Westminster Local Involvement Network
Whipps Cross University Hospital NHS Trust
Wigan Borough Clinical Commissioning Group
Worcestershire Acute Hospitals Trust

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Wound Care Alliance UK
Wren Hall Nursing Home
Wye Valley NHS Trust
York Hospitals NHS Foundation Trust
Your Turn

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