Professional Record Standards Body

Better records for better care

Nursing Care Needs Standard

FINAL REPORT

October 2023

Document Management

Revision History

Version	Date	Summary of Changes
0.1	18/08/23	First draft
0.2	06/09/23	Updated with information from Digital Nursing Expert Review Workshop, and the Nursing Survey
0.3	13/09/23	Updated following feedback from reviewers of V0.2
0.4	02/10/23	Updated following feedback from Assurance committee and change of standard's name

Reviewers

Reviewer name	Title / Responsibility	Date	Version
Paula Anderson	CNIO, UCLH	01/09/23	0.1
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Paula Anderson	CNIO, UCLH	13/09/23	0.2
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Name	Title/Responsibility	Date	Version
Assurance Committee	Assurance Committee	28/09/23	0.3
Project Board	Project Board	27/09/23	0.3

Glossary of Terms

Term / Abbreviation	What it stands for
ADL	Activities of Daily Living
ANP	Advanced Nurse Practitioner
C-HOBIC	Canadian Health Outcomes for Better Information and Care
CIC	Community Interest Company
CIS	Core Information Standard
CNIO	Chief Nursing Information Officer
CNS	Clinical Nurse Specialist

DAPB	Data Alliance Partnership Board
ePMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
FHIR	Fast Healthcare Interoperability Resources
FOT	First of Type
HCPC	Health and Care Professions Council
ICS	Integrated Care Systems
IDDSI	International Dysphagia Diet Standardisation Initiative
IMS	Information Management System
ISN	Information Standards Notice
MUST	Malnutrition Universal Screening Tool
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
PRSB	Professional Record Standards Body
SNOMED CT	Systematized Nomenclature of Medicine Clinical Terms
TFM	Tube Feeding Methods
UK	United Kingdom
ZIBs	Zorginformatiebouwstenen – A Dutch clinical information model

Planned Review Date and Route for User Feedback

The next maintenance review of this document is planned for October 2026, subject to agreement with NHS England as the commissioning body.

Please direct any comments or enquiries related to the project report and implementation of the standard to support@theprsb.org .

Contents

1 Executive Summary

This comprehensive report details the development of a Nursing Care Needs Standard, following a structured process encompassing Discovery, Scoping, Draft Standard Development, Consultation, and Finalisation. The consultations engaged multidisciplinary professionals, clinical system suppliers, and digital nursing experts, providing a diverse perspective on the development of the draft Nursing Care Needs Standard.

Background and Context

The initiative stems from the imperative to standardise nursing documentation for enhanced patient care and efficient data utilisation. The project acknowledges the vital role of digitalisation in modern healthcare and aims to bridge the gap between analogue practices and the potential benefits of digital integration.

Methodology

The methodology involved a multi-phase approach, beginning with Discovery and Scoping to define the scope and objectives. Development of the draft standard aimed to outline the nursing initial assessment, incorporating valuable inputs from various stakeholders. Extensive consultations further refined the standard, involving multidisciplinary professionals, system suppliers, and digital nursing experts.

Deliverables

Following the robust consultations in the development of the Nursing Care Needs Standard, the deliverables are reported in the following seven documents:

1. Nursing Care Needs Standard Final Report
2. Nursing Care Needs Standard – an information model (Excel)
3. Survey Report
4. Nursing Care Needs Standard Hazard Log
5. Clinical Safety Case Report
6. General Implementation Guidance
7. Business Rules

Consultation Insights

Participants emphasised streamlining nursing documentation processes, aiming to reduce administrative burdens. Integration with clinical systems and condensing related questions were recommended to enhance efficiency without compromising data comprehensiveness. Key themes across consultations include:

- Enhancing assessments
- Standardisation of terminology
- Redesigning assessments
- Challenges with provider organisations
- Use of professional judgement
- Interoperability and integration

Key Recommendations

Several recommendations emerged from the consultation process, including the need for a First of Type (FOT) implementation, defining transactions between systems, developing support materials, and engaging with National Health Service England (NHSE) Terminology team for code development. Seeking Data Alliance Partnership Board (DAPB) assurance, inclusion in NHSE's standards register, and considering incorporation into existing frameworks were also highlighted.

Conclusion and Next Steps

The Nursing Care Needs Standard represents a significant advancement in nursing care assessments, with broad support from stakeholders. To ensure smooth adoption, technical components, community activation, barrier identification, and incentive leveraging are crucial focal points. This standard promises to enhance the quality and efficiency of nursing care assessments, ultimately improving patient outcomes in healthcare settings.

2 Introduction

2.1 Background and Context

Nurses are essential to healthcare, playing a pivotal role across diverse sectors and serving as a cornerstone of expertise for both patients and fellow professionals. Their significance in healthcare is unparalleled, as nursing is an integral component of care delivery in virtually every healthcare setting. Nurses constitute one of the largest workforces in health and care, making their contributions key to the field's advancements[1]. In the United Kingdom (UK), there are over 788,638 registered nurses, midwives, and nursing associates as of March 2023, with nurses accounting for an overwhelming 92.7% of the Nursing and Midwifery Council (NMC) workforce. Furthermore, a growing year-on-year increase is observed; in 2023, a record-breaking 52,000 new nurses joined the ranks[2].

However, a critical challenge persists: the lack of standardisation in nursing documentation and communication. This deficiency results in a wide spectrum of practices, creating disparities both within and between healthcare organisations, care settings, and nursing specialties.

It is imperative that the importance of nurses in the healthcare workforce is recognised to ensure optimal clinical care and patient outcomes. Equally vital is the standardisation of nursing documentation, which will not only streamline processes but also enhance the quality of care delivered. Standardisation is an essential tool to empower nurses to provide the best possible care, ultimately benefiting patients and the entire healthcare ecosystem.

The National Health Service (NHS) has led a significant shift towards locally determined, controlled, and funded health and social care systems. This transformation, outlined in the NHS Long Term Plan[3], extends its influence on the devolved nations of the UK – a testament to the overarching commitment to integrated care (Northern Ireland Health and Wellbeing 2026[4], Scotland Health and Social Care Integration[5]).

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[1] Royal College of Nursing: The UK nursing labour market review 2018, RCN, January 2019 Publication code 007 397

[2] Nursing & Midwifery Council. Registration data reports. [Online] Available at: https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/

3 NHS (2019). NHS Long Term Plan Implementation Framework 2 I NHS Long Term Plan Implementation Framework Contents. [online] Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf.

4 Department of Health (2016). HEALTH AND WELLBEING 2026 DELIVERING TOGETHER. [online] Available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf.

5 Scottish Government (2016). Social care: Health and social care integration - gov.scot. [online] www.gov.scot. Available at: https://www.gov.scot/policies/social-care/health-and-social-care-integration/.

At its core, health and social care integration strives to forge a seamless care experience for those with combined health and social care needs. This is underpinned by the pivotal role of integrated, multidisciplinary teams and the necessary organisational and technological infrastructure that supports this collaborative approach. In each nation, digital solutions and data play pivotal roles in ensuring the safety and efficacy of integrated care, yet a significant hurdle arises from disparities in documentation practices and information sharing across health and social care domains, leading to a lack of coordination between health and care providers.

The pandemic has accelerated the adoption of digital tools and systems among frontline health and care staff, along with a surge in citizen engagement with digital services. These changes highlighted the importance of standards, guaranteeing that digitally exchanged information is unequivocal, timely, and supports high-quality care. Co-producing these standards with frontline health and care workers, along with service users, guarantees that they remain person-centred. This standardised approach not only enhances interoperability but also streamlines workflows, affording more time for care provision.

Crucially, patient and citizen involvement at every level, in every stage, and across all workstreams in this national endeavour is paramount. This approach ensures that citizens are equal partners in their care, fostering self-care and enabling them to drive and evaluate outcomes that matter most to them. A collaboratively developed national standard promises to improve interoperability, promote collaborative working, and facilitate shared decision-making. The potential benefits, spanning patients, nurses, and the broader healthcare system, are manifold, ultimately translating to a substantial enhancement in care quality and safety over the long term.

Addressing the need to refine nursing information architecture, the NHSE Digital Nursing Programme entrusted the Professional Record Standards Body (PRSB) with a comprehensive discovery project. The findings, submitted in July 2021, underscore the pivotal role of nursing documentation and communications within a person's circle of care. The project underscored that achieving integrated care hinges on concurrent consideration of documentation practices, information needs, and integration of both social care and healthcare.

In August 2022, NHSE commissioned the PRSB for the scoping phase, with a clear goal: to establish a nursing documentation standard that addresses key areas of nurse-led care, with a focal point on patient/person nursing care assessments – a pivotal aspect of nursing documentation. This phase ran concurrently with other nursing documentation standardisation projects, all converging towards the creation of a unified framework for standardised nursing documentation.

Following a thorough review of the three strands of Nursing Standardisation projects, NHSE, in consultation with key nursing stakeholders, concluded that the core of the Nursing Care Needs Standard should revolve around the functional care needs of individuals, enabling them to lead their best lives. Thus, NHSE has commissioned the PRSB to develop a Nursing Care Needs Standard based on the functional needs of individuals, building upon the work completed thus far in relation to the Nursing Care Needs Standard.

3 Methodology and Consultation Approach

3.1 Methodology

3.1.1 Objectives

The overarching aims of this project are to develop a nursing documentation standard requirements specification for key areas of nurse-led care, with a focus on patient/person nursing care assessments.

The objectives were to:

- Develop a Nursing Care Needs Standard (functional needs) including documentation to support progression to the DAPB for an Information Standards Notice (ISN).
- Recommend any changes to the Core Information Standard for implementation through the PRSB's support and maintenance service.
- Seek endorsement support to capture input from professional groups and non-professional groups.

3.1.2 Project Phases

The project was delivered across the following phases:

1. Discovery
    a. In consideration of the need to improve the structure of nursing information, NHSE digital nursing program commissioned PRSB to conduct a discovery project which is now complete, and the final report submitted in July 2021.
    b. Discovered a collaboratively developed national standard should improve interoperability, collaborative working and shared decision making.
    c. The potential benefits derived for patients, nurses, and the system include improved care quality and safety, can be significant in the long term.
2. Scoping
    a. NHSE commissioned PRSB for the scoping phase of the project in August 2022, with an overall aim to develop a nursing documentation standard requirements specification for key areas of nurse-led care.
    b. Nursing documentation standardisation projects and a review of international nursing data standards was undertaken in parallel by NHSE with the ambition to bring these strands of work together.
    c. NHSE concluded that the core of the Nursing Care Needs Standard should be focused on the functional care needs of individuals.
3. Development of draft standard
    a. Develop a draft information model from the requirements found in Phase 2, based on functional needs of a person.
    b. Develop to encapsulate adult and children, as well as hospital care, nursing homes, and community nursing care.
4. Consultation
    a. Engagement with the National Project Director for Canadian Health Outcomes for Better Information and Care (C-HOBIC), who is also a co-Lead National Nursing Data Standards Initiative and a member of the Canadian Nurses Association.
    b. One webinar with a multidisciplinary group of nurses from various backgrounds and settings.
    c. One webinar with system suppliers.
    d. One survey distributed to nurses.

e. Engagement with an NHSE clinical terminologist.
f. Workshop with the Nursing Programme Practice and Research Workstream Group.
g. Engagement with Digital Social Care team.

5. Finalisation of standards and drafting of supporting materials
    a. Implementation guidance.
    b. Clinical safety report and hazard log.
    c. Submission of requests for new Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) codes.

3.1.3 Scope

The scope of this project was defined based on the previous phases, which included a review of key literature, and conversations with professionals and citizens.

In scope

The nursing led care in scope is the first nursing care contact assessment. The standard focuses on eating and drinking, mobility, elimination (toileting and continence), personal hygiene and dressing, skin, and medication self-management. 'Must have' data items and business rules for the standard will also be developed for partner conformance assessment.

The care settings in scope are:

- Hospital
- Community
- Care Home with Nursing

Out of scope

Mandating which specific risk assessment tool should be used for an assessment.

Nurse treatment plans used by Clinical Nurse Specialists (CNS) and Advanced Nurse Practitioners (ANP) and in non-inpatient care settings.

The following clinical specialities and their patients' needs have not been considered when developing this standard:

- Midwifery
- Neonatal care
- Mental health nursing

Although the inclusion and exclusion criteria are short, they are not exhaustive. Discussion identified that there will be many care settings that assess functional needs, including mental health. This standard should be used in care settings where it is relevant.

3.1.4 Project Team

The project team is set out in Appendix A and consisted of NHSE representatives, a clinical lead, and a citizen lead, and the PRSB team.

3.2 Consultation Approach

An evidence review was completed in the previous phases of this project and included:

- In the discovery phase: a targeted review of published international literature and group semi-structured interviews of key stakeholders focused on feasibility, benefit and best

practices, challenges, and risks, and arriving at a shared understanding of a Nursing Care Needs Standard[6].

- In the scoping phase: a targeted review of nursing risk assessment tools used in England (mapped against each other and supplemented with relevant regulatory and national guidance) and UK national nursing documentation standards initiatives. Focus groups, interviews and a survey were used to clarify how, why and which assessments were used by nurses to inform the core content of a standardised assessment[7].

Throughout the project, regular discussions took place during weekly team meetings with the clinical and citizen leads to agree changes to the standard.

Further engagement with NHSE team members were scheduled fortnightly.

3.2.1 Development of the Draft Standard

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

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

The draft standards were iteratively developed following review and mapping of existing standards, the literature, discussions, webinars, workshops, and a survey.

3.2.2 Webinars

A wide range of discussions took place over the course of the project with multidisciplinary professionals and clinical system suppliers.

Two webinars took place during July 2023. The webinars were recorded, and the transcript and chat were analysed for themes, which structured the recommendations to update the information model. The questions asked are set out in Appendix B.

Webinar 1 (multidisciplinary) was held on Thursday 13th July 2023 **(144 attendees, see Appendix C).**

Webinar 2 (system suppliers) was held on Wednesday 19th July 2023 **(38 attendees, see Appendix D).**

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[6] The Professional Record Standards Body (2021). *Nursing Care Needs Standard Discovery Report*. [online] Available at: HYPERLINK "https://theprsb.org/wp-content/uploads/2021/11/Nursing-Standard-Discovery-Report-V2.1.pdf"https://theprsb.org/wp-content/uploads/2021/11/Nursing-Standard-Discovery-Report-V2.1.pdf.

[7] The Professional Record Standards Body (2022). *Nursing Assessment Standard - Requirements Scoping Report*.

3.2.3 Survey

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

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

A total of 483 responses were collected, with only 418 being analysed due to the remaining 65 responses being incomplete. SurveyMonkey generated the quantitative outputs, and a thematic analysis was conducted on the additional comments and suggestions per each section and overall standard. See Appendix I for a link to the survey report, including the questions and analysis.

The survey consisted of 4 parts:

1. **Demographic questions**: Questions that asked the respondent about their Nursing and Midwifery Council (NMC) registration, the setting they work in, and their job title.
2. **Proposed section elements review:** Respondents were presented with the proposed elements in each new section of the standard and asked to check any element that they felt did not belong in the standard.
3. **Missing elements in sections:** Respondents were provided with the opportunity to indicate whether they felt any crucial elements were missing from each section, and if so, they were given a free text box to elaborate.
4. **General feedback:** At the end of the survey respondents were given the opportunity to provide any final feedback on the standard in its entirety.

3.2.4 Digital Nursing Expert Review Workshop

A workshop was held with the Nursing Programme Practice and Research Workstream Group on Wednesday 16th of August 2023 **(20 attendees, see Appendix E).**

3.2.5 Digital Social Care team

Engagement with members of the NHSE's Digital Social Care team ensured the Nursing Care Needs Standard Development was aligned with the social care perspective and its touchpoints, e.g., Care homes with nursing. The Social Care Team have produced invaluable tools, which have undergone clinical terminology mapping. As an outcome of our conversation, a review was undertaken in the areas that are within scope of our project, alongside our analysis.

The development of the Nursing Care Needs Standard by the PRSB was influenced by the Core Information Standard and extensive input from clinicians, with a focus on clinical datasets and Activities of Daily Living (ADLs). New data sections were created to capture relevant information across various healthcare settings for both adults and children. The standard will follow a similar process as the Minimum Operational dataset (MODS) beta, including requesting new codes and engaging with the Fast Healthcare Interoperability Resources (FHIR) team for pathway development. In summary, the nursing sections were

created in alignment with the CIS and PRSB standards, with no current data element overlap, ensuring a harmonious integration.

3.2.6 Deliverables

Following the robust consultations in the development of the Nursing Care Needs Standard, the deliverables are reported in the following seven documents:

8. Nursing Care Needs Standard Final Report
9. Nursing Care Needs Standard – an information model (Excel)
10. Survey Report
11. Nursing Care Needs Standard Hazard Log
12. Clinical Safety Case Report
13. General Implementation Guidance
14. Business Rules

4 Findings and Recommendations

4.1 Multidisciplinary Webinar Findings

Due to high engagement with the multidisciplinary webinar, there was a variety of feedback on the standard. This ranged from specific items that individuals felt were missing or unnecessarily included in the standard, to overall concerns and suggestions about the standard. Many suggestions were made for data items that could be added to the standard; however, several suggestions were likely to be too specialised for an initial assessment. These items were consulted with the clinical lead for the project to assess suitability and implemented as appropriate. Furthermore, some items were suggested which were covered in other sections of the proposed standard, and so have not been added to minimise duplication. Table 8 summarises the general feedback themes and recommendations from the webinar. Table 9 summarises the changes to each section on an element level. Both tables can be found in Appendix F.

4.2 Supplier Webinar Findings

Overall, there was positive feedback from system suppliers about the development of the Nursing Care Needs Standard. Participants highlighted the importance of the Nursing Care Needs Standard for nurses and patients, and the final product was highly anticipated.

System suppliers did not provide much feedback regarding the content of data items for the Nursing sections; the inclusion of ‘fear of falling’ was positively called by one participant. It was stressed that clinical providers and organisations have a responsibility to steer and guide the usage and development of digital standards, in which system suppliers have the capability to code any data items.

There is a need for cultural transformation across the Nursing practice. The use of targeted education on the benefits of digitisation in health and social care would increase knowledge of benefits and enable behavioural change, which could increase the ease the implementation of the Nursing Care Needs Standard in practice.

By prioritising behavioural change and acceptance, this will in hand reduce nursing burden and enhance clinical care and patient outcomes.

Table 10 in Appendix G shows an overview of the key themes that were discussed during the webinar.

4.3 Digital Nursing Expert Review Workshop Findings

There was a collection of points related to the various aspects of clinical assessment in nursing. Table 11 summarises the general feedback themes and recommendations from the workshop. Table 12 summarises the comments and recommendations of each section of the standard. Both tables can be found in in Appendix H. The sections Skin and Medication Self-Management were requested to be reviewed externally of the workshop due to time constraints.

The Digital Nursing Expert group emphasised the importance of clear and standardized information collection, clinical judgement, and adapting assessments to various care settings and patient conditions.

4.4 Survey Findings

4.4.1 Part 1 - Demographic Questions

The survey aimed to test the suitability of the content of the Nursing Care Needs Standard with the people who will use it. It provided an opportunity to better understand issues that may affect the implementation of the standard in practice and the potential impact on people who will use them.

A total of 483 responses were collected, with only 418 being analysed due to the remaining 65 responses being incomplete. Of the 418, 43 responses were excluded from the analysis of the demographic questions as these questions were amended as the survey was live to allow for a greater breadth of data to be collected. The majority (95.72%) of the respondents were registered nurses and/ or midwifes on the NMC register, and the remaining included individuals who were qualified nurses currently not registered, registered nursing associates, trainee nursing associates, currently on non-practicing registrations, health care professionals, Health and Care Professions Council (HCPC) registered, digital clinical systems developers and social workers. The majority (84.76%) of registered nurses worked with adults and 6.68% worked with children.

4.4.2 Part 2 - Proposed Section Elements Review

Respondents were presented with the proposed elements in each new section of the standard and asked to check any element that they felt did not belong in the standard. There was a lack of majority (≥50%) responses towards removing a data element; therefore, no data elements were removed based on the feedback from these questions.

4.4.3 Part 3 – Missing Elements in Sections

Respondents were provided with the opportunity to indicate whether they felt any crucial elements were missing from each section, and if so, they were given a free text box to elaborate. Table 1 shows the response rate for this question for each new section of the standard.

Section name	Percentage of responses to the question “Considering the above elements, do you think any elements are missing?” at each section (%)

	Yes	No	Prefer to not say
Eating and drinking	33.94	62.92	3.13
Mobility	27.50	68.33	4.17
Elimination (Toileting and continence)	26.02	70.47	3.51
Personal hygiene and dressing	21.26	75.15	3.59
Skin	29.00	67.98	3.02
Medication self-management	29.81	65.84	4.35

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

Most respondents, shown in Table 1, selected 'No' after considering if there were any data elements missing. This suggests that most nurses considered the data elements in each section were comprehensive and clinically relevant for the purpose of initial assessment upon admission for adults and children across the three settings in scope. The feedback from those who responded 'Yes' was analysed and can be found in the Survey Report in Appendix I. A summary of the key themes for each section can be found below.

4.4.3.1 Eating and Drinking

There was stress for the need to avoid duplication, enhance the structure, and include vital elements to provide a more meaningful assessment of a patient's nutritional status. They stressed the importance of having a sole source for critical measurements, such as height and weight, to prevent duplications in a patient's records.

Some respondents recommended the addition of crucial elements to the assessment, which are included in the Survey Report (Appendix I). The inclusion of these elements would provide a more comprehensive understanding of the patient's nutritional status. Furthermore, reviewers advocated for clearer definitions, such as utilising the IDDSI (International Dysphagia Diet Standardisation Initiative) framework for assessing food and fluid textures and propose combining related questions.

Finally, there were many concerns about the documentation's ability to support interoperability and seamless integration into the healthcare record-keeping system, which underscore the need of a structured process that aligns with standardised terminologies, such as SNOMED CT, and integrates seamlessly with care planning.

4.4.3.2 Mobilisation

Several health problems that restrict mobility, such as obesity, breathing difficulties, and the use of prosthetics, were highlighted to emphasise the need to consider specific health conditions in mobility assessments. Respondents also stressed the importance of assessing cognitive abilities and techniques to promote patient compliance with mobility tasks. Also, the survey acknowledged the impact of conditions like epilepsy and dementia on perception, cognition, and mobility.

Several survey responses indicated the need to include medication review, especially in cases of polypharmacy, to identify and address medications that may increase the risk of falls. This emphasised the importance of considering the effects of medication on patient safety and mobility during the initial nursing assessment.

Inappropriate clinical terminology was a significant concern, with numerous comments highlighting the need to replace "cot sides" with "bed rails" in clinical documents. Respondents suggested updating all terminologies to align with contemporary practices and standards. The consensus from the respondents is for consistent and suitable language that is appropriate in both adult and paediatric care settings.

Respondents stated the significance of blood pressure monitoring, especially when transitioning between positions like standing to sitting or lying down. This monitoring plays a critical role in detecting hypotension, where blood pressure significantly decreases with changes in position. Identifying postural drop is crucial, as it is associated with an elevated risk of falls.

Some respondents emphasised the need to reduce documentation burden on nurses. This includes suggestions to integrate with other clinical systems to prepopulate information (Electronic Prescribing and Medicines Administration [ePMA] systems), eliminate repetition (e.g., merging frailty and mobility questions), merge related questions (e.g., combining unexplained falls and falls in the past 12 months).

4.4.3.3 Elimination (Toileting and Continence)

Some respondents emphasised the significance of dietary and fluid considerations as influential factors in urinary and bowel patterns. Consequently, assessments should include enquiries about dietary choices and daily fluid intake. This information assists healthcare professionals in obtaining a holistic understanding of a patient's elimination habits, enabling them to deliver more effective care.

The ability of patients to self-manage conditions such as stomas received considerable attention, with respondents suggesting that evaluating this capability is pivotal. Determining whether patients can independently manage their condition or require support allows for the tailoring of care plans. Furthermore, acknowledging the role of caregivers, both within and outside the hospital, ensures the continuity of care, particularly for patients with ongoing elimination requirements.

Respondents underscored the importance of documenting medications that may impact elimination and considering specific health conditions affecting continence, such as urinary tract infections, gastrointestinal disorders, or neurological conditions. This comprehensive approach ensures that healthcare providers consider all relevant factors that could affect a patient's elimination and continence.

Efficiency in nursing documentation was another key aspect discussed by respondents. Strategies to alleviate the data entry burden on healthcare professionals were suggested, including prepopulating data from existing records and consolidating sections to minimise redundant input. Streamlining the documentation process can save valuable time and nursing resources.

4.4.3.4 Personal Hygiene and Dressing

Several comments highlighted the need to either merge or eliminate the questions related to the condition of the mouth, as it is repetitive or better addressed in other sections. Many comments suggest combining questions related to problems with hands and feet and integrating them with mobility assessments. Multiple comments mention the importance of

capturing patient preferences. Several comments mention the importance of considering cognitive impairments, mental health issues, and their impact on personal hygiene and dressing. Furthermore, comments also suggested that the standard should include questions about skin conditions and their impact on dressing and hygiene routines. Multiple comments emphasise the importance of assessing the level of assistance or support a patient requires from caregivers.

4.4.3.5 Skin

Many comments focused on assessing and preventing pressure ulcers, including the use of pressure-relieving equipment and risk assessments. Some comments highlighted that elements relating to medication would not be relevant, as they are in other parts of the patient record. Some comments revolved around assessing and caring for the skin, including aspects like skin type, hydration, moles, and visual inspection.

The theme of the patient's ability to change position was brought up in relation to the mobility section, including relocating the elements to the mobility section and removing duplication with the mobility section. Wound care was frequently mentioned, including comments relating to wound care products, treatment plans, and wound history. Also, there were several concerns about allergies. Some comments mentioned moisture affecting skin, particularly in relation to continence. Pain was also mentioned several times, with some suggesting that pain is not appropriate to capture here as it can affect things other than skin, and some suggesting more pain options be added.

4.4.3.6 Medication Self-Management

Some respondents propose streamlining the assessment process by merging certain elements, like combining questions about the usual administrator of medication and the administrator at nursery/school/college into a single item where the setting can be specified. This approach aimed to maintain a holistic understanding of medication self-management while reducing redundancy.

Some respondents expressed concerns about the feasibility of nurses completing all the listed questions for every patient or service user, emphasizing the need for a balance between comprehensiveness and practicality. They stressed the importance of supporting nurses in thinking holistically about the assessment without overwhelming them with an extensive list of questions.

4.4.4 Part 4 – General Feedback

At the end of the survey respondents were given the opportunity to provide any final feedback on the standard in its entirety. The feedback on the standard is diverse, encompassing various perspectives and suggestions for refinement. Several key themes emerge from the comments shown in the Survey Report in Appendix I.

There was positive feedback on the Nursing Care Needs Standard. Many individuals expressed their appreciation for the comprehensive nature of the standard and its potential to bring about positive changes in healthcare services. They valued the initiative's focus on using objective quantitative metrics to enhance data utilisation for service improvement and emphasised the need for a national standard across the NHS. The standard was regarded as intelligent, thorough, and well thought out, with an emphasis on the importance of accurate and up-to-date information. However, there were concerns about potential

repetition in questioning across various categories and the need to ensure that assessments are conducted efficiently, without redundant questioning.

The feedback underscores the importance of striking a balance between comprehensiveness and usability in the standard. Also, respondents emphasized the need for a patient-centred, adaptable, and streamlined approach that considers the unique needs of different patient populations while avoiding duplication and complexity in the assessment process. How this assessment will integrate into digital systems was frequently inquired into and its potential commented on. The need for a structured process that aligns with standardised terminologies, such as SNOMED CT, was emphasised to help promote seamless integration with care planning.

Overall, the feedback highlighted the importance of this Nursing Care Needs Standard in improving healthcare services, while also urging for thoughtful implementation to avoid unnecessary duplication and to streamline the assessment process for the benefit of patients and healthcare staff.

4.5 Key Findings Across Consultations

See Table 2 for a summary of the key findings across all the consultations conducted during this project.

Efficient Nursing Documentation	
Efforts to streamline nursing documentation processes were a central theme in the discussions. Participants emphasised the importance of reducing the administrative burden on nurses. Some participants proposed strategy involving integrating nursing documentation with other clinical systems. These integrations would allow for the seamless pre-population of patient data, significantly reducing the need for redundant data entry. Additionally, suggestions were made to merge related questions within the initial assessments, such as questions related to frailty and mobility. These steps aim to not only save valuable time and resources but also enhance the overall efficiency of healthcare documentation.	• Concerns about size of standard and the number of mandatory elements. • The interdependence of ADLs like nutrition affecting mobility and skin integrity can result in duplicated assessment information when separate headings are used, posing a risk of replication in collected data. • Minimise free-text inputs and consider tailoring data item responses, emphasising the importance of data collection driven by conditional logic to avoid overwhelming nurses with excessive questions during nursing assessments. • The need for efficient, streamlined documentation with a focus on meaningful and essential data items.
Enhancing Comprehensive Assessments	
The discussions emphasised the importance of enhancing assessments to	• Concerns about data items incorporating logical operators like

capture a broader range of patient information. Recommendations included incorporating additional elements in assessments related to nutrition, mobility, and medication self-management. This expanded approach aims to provide a more holistic understanding of a patient's health status, supporting comprehensive and tailored patient care plans.	"AND" or "OR" and their implications, especially for patients with multiple conditions. • Participants stressed the need for redesigning mobility assessments to make them more user-friendly and applicable across various healthcare settings. This evolution aims to improve the quality of patient care beyond traditional nursing boundaries. • Uncertainty about whether specific assessment sections should be mandatory for patients with relevant issues, allowing flexibility for others.
Standardisation of Clinical Terminology	
Standardising clinical terminologies emerged as a crucial theme in the discussions. Attendees stressed the importance of using standardised clinical language to ensure clarity and consistency in healthcare documentation. By adhering to uniform terminology, healthcare professionals can effectively communicate and share patient information across various healthcare settings. This commitment to standardised language enhances data accuracy and, ultimately, the quality of patient care.	• Concerns about the number of free text options. • A push for SNOMED CT to be utilised where possible to improve interoperability. • Making the titles of each section reflect terminology already used in nursing. • Reference to the Dutch ZIBs model being SNOMED coded where possible.
Redesigning the Assessment	
The theme of redesigning the assessment for improved user-friendliness, particularly mobility was a key point of discussion. Participants acknowledged that the draft initial assessment, while detailed, may not be easily applicable across diverse healthcare settings. The goal is to retain the necessary level of detail while making the initial assessments accessible and user-friendly for a wider range of healthcare professionals. This redesign, the participants stated is to ensure that critical information is captured without	• Mentions that there is too much data to capture for every person the nurse is assessing. • Shifting focus to initial assessment of ADLs, such as in C-HOBIC, and then triggering specialist assessments if there are issues. • Concerns about the project remit and establishing a minimum dataset of clinical information. • There is already a documentation burden for nurses and this standard

overwhelming healthcare providers with overly complex assessments.	risks increasing it rather than reducing it.
Provider Organisation Challenges	
An important theme that surfaced was the reluctance of healthcare provider organisations to embrace standardised approaches. During the discussions, it was recognised that different healthcare trusts and organisations may have their distinct designs and practices when it comes to initial assessments. Furthermore, some providers are reluctant to lean into the digitisation of health care records. This resistance can create hurdles in achieving consistency in healthcare documentation and practices across the healthcare landscape. Addressing this challenge requires developing strategies to bridge the gap between individual provider organisations and advocate for the broader adoption of standardised tools and methodologies.	• Suppliers highlighted that they are capable of coding the data elements provided to them, though the usage of the standard is determined by the providers. • Some mentioned how analogue practices can hold us back, and further education on the benefits of digitisation would be advantageous.
Use of Professional Judgement	
Multiple people who engaged in consultation expressed concerns about how the standard may constrain nurses and their ability to make professional judgements on how to treat each person they work with. Some mentioned how other assessments would be preferred in certain use cases, and others believed that the dataset itself would limit what information nurses could record. To address this, nurses should be empowered to exercise professional judgement when using the standard, by allowing areas for them to make additional comments and not defining which assessments should be triggered by particular answers to elements in the standard.	• Mention of how models of nursing guide the standard was mentioned. PRSB has not developed the standard from a single model of nursing, to allow nurses to continue to use the models that they are currently using. • Suggestion to empower nurses to exercise professional judgement when applying standards. • There were concerns about language used in some elements, such as the use of the word “capability”, however nurses should use their own judgement on what language to use when asking patients questions regarding these data elements.

Interoperability and Integration	
Interoperability and integration of healthcare systems were highlighted as crucial aspects. Concerns were raised about the ability of documentation systems to support seamless data sharing across different healthcare settings. Achieving interoperability involves structuring documentation processes to align with standardised terminologies like SNOMED CT and the NHS data dictionary. This ensures that patient data can be effectively communicated and used across various healthcare systems and settings.	• Concerns arose over sharing information between different systems. They must conform to standards. Technical and commercial conformance is necessary for effective interoperability and information sharing across applications and systems. • The Nursing Care Needs Standard is based on PRSB's CIS, currently being implemented in Integrated Care Systems. However, its current implementation level is unclear. Implementing the Core Information Standard is not a pre-requisite to the Nursing Care Needs Standard. However, systems already compliant with the CIS will require less adaptation. • Not all systems need to fully comply with the standard. They only need to adhere to a subset relevant to their products. For instance, an acute setting will not require compliance with information specific to a nurse-led care home. • UK Fast Healthcare Interoperability Resources (FHIR) core is under development. The Nursing Care Needs Standard must be mapped to the existing UK FHIR core profiles to identify gaps. A pragmatic approach is needed to develop technical standards for immediate implementation.

***Table 2**. A table the key findings across all of the consultations conducted.*

4.6 Recommendations

1. Undertake First of Type (FOT) implementation of the Nursing Care Needs Standard in a clinical context with the ambition to:
    - Test and refine the standard to ensure that it is functional and applicable to both adult and paediatrics, as well as the three in-scope settings (Hospital, Community, and Nursing home).

    - Define transactions between systems and design an architectural approach for implementation.
    - Development of support materials for implementers and which would help to inform a national architectural strategy.
2. Engagement with NHSE Terminology team to ensure that required SNOMED CT codes for the Nursing Care Needs Standard are developed and that there is a defined process for maintaining the codes.
3. Seek Data Alliance Partnership Board (DAPB) assurance for the Nursing Care Needs Standard. DAPB assurance would mandate system providers to implement the standard.
4. Ensure that the Nursing Care Needs Standard is included in the NHSE's standards register.
5. Consider the use of other incentives, for example, incorporating the Nursing Care Needs Standard into the What Good Looks Like framework[8], the Integrated Care Systems (ICS) mandates[9], and the National Institute for Health and Care Excellence (NICE) guidelines[10].
6. Consider how conformance with standards should be assessed and work with procurement framework leads to agree and implement an approach.

5 Conclusion

In conclusion, there was broad support for the development of the Nursing Care Needs Standard throughout the consultation process across multidisciplinary professionals and clinical system suppliers. It is necessary to build on the foundation of support to ensure adoption of the standard is effortless by developing the technical components critical to support the sharing of information; activating a community of willing participants to promote the standards; continuing to identify and address perceived barriers to implementation; and identifying and activating levers and incentives to drive adoption.

6 Appendix A – Project Team

Role	Name
Chief Nursing Information Officer (CNIO), UCLH	Paula Anderson
Project Manager & Lead Analyst	Kingsley Ejeh
Project Analyst / Project Coordinator	Caitlin O'Donnell

[8] NHS Transformation Directorate. (n.d.). What Good Looks Like framework. [online] Available at: https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/.

9 www.england.nhs.uk. (n.d.). NHS England» Key documents for Integrated Care Systems. [online] Available at: https://www.england.nhs.uk/integratedcare/resources/key-documents/.

10 National Institute for Health and Care Excellence (2018). Find guidance | NICE. [online] NICE. Available at: https://www.nice.org.uk/guidance.

Project Analyst	Kelly Cheng
Clinical Lead	Ian Woodburn
Citizen Lead	Emma Robertson
Senior Clinical Lead, NHSE	Chris Dickson
Communication and Engagement Lead	Helene Feger
Head of Stakeholder Relations	Daniel Edmonds
Project Support	Alison Brown

Table 3. *A table showing the names and roles of members of the project team.*

7 Appendix B – Questions Asked at Webinars

Attendees of the webinars were shown the proposed elements for each of the new Nursing sections and asked the following questions:

Question	Webinar
Are the [section name] data items sufficient?	Multidisciplinary and Supplier
Are any categories of information missing / unnecessary?	Multidisciplinary and Supplier
Do you feel that these items effectively cover the three settings that are in scope? • Hospital • Community • Nursing home	Multidisciplinary
Do you feel that these items effectively cover both adult and child needs?	Multidisciplinary

Table 4. *A table showing the questions asked to attendees at both webinars, after being shown each new nursing section.*

Attendees were then asked the following questions, after they had reviewed all the proposed sections.

Question	Webinar
Does the proposed standard seem sufficient in meeting the needs of the nurses who may be using the standard?	Supplier
Are there likely to be any problems or constraints in developing the Nursing Care Needs Standard?	Supplier
Have you got previous experience of providing functionality in this area?	Supplier
Are there any issues you have come across with any of our other standards which aren't being addressed?	Supplier

Are there likely to be any problems or constraints in using the Nursing Care Needs Standard?	Multidisciplinary

Table 6. *A table showing the questions asked to attendees at both webinars, after seeing the entirety of the newly proposed Nursing Care Needs Standard sections.*

8 Appendix C – Multidisciplinary Webinar Attendees List

144 Attendees, including PRSB and project team.

Role	Organisation
Head of Communications, Engagement and Strategy	PRSB
Head of Stakeholder Relations	PRSB
Project Manager	PRSB
Project Analyst	PRSB
Project Analyst	PRSB
Chief Nursing Information Officer/ Clinical Lead	PRSB
Citizen Lead	PRSB
Senior Business Analyst	PRSB
Chief Nursing Information Officer	ULCH/ NHS E
Senior Programme Manager	NHS England
Digital Nurse	Airedale NHS Foundation Trust
Chief Nursing Information Officer	Barnsley Hospital
Digital Midwife	Bedford Hospital NHS Trust
Senior CSO	Bedfordshire Hospitals NHS Foundation Trust
Staff Nurse	Betsi Cadwaladr University Health Board/ NHS Wales
SCPHN- SN	BMBC 0-19 PHN
Senior Electronic Systems Configuration Analyst	Bolton NHS Foundation Trust
CNIO	Bolton NHS Foundation Trust
Head of Clinical Systems	Bolton NHS Foundation Trust
Clinical Systems Configuration & Testing Manager	Bolton NHS Foundation Trust
Senior Clinical Informatics Nurse	Bolton NHS Foundation Trust
Operational Manger - unplanned care	Bradford District Care NHS Foundation Trust
Digital Clinical Systems Lead	Bradford District Care NHS Foundation Trust

Chief Nursing Information Officer	Bridgewater Community Healthcare NHS Trust
Clinical Information Systems Manager	City Health Care Partnership CIC
Chief Nursing Information Officer	Clatterbridge Cancer Centre NHS Foundation Trust
Assistant Director of Nursing	Coventry and Warwickshire Partnership NHS Trust
Head of digital nursing	Coventry and Warwickshire Partnership NHS Trust
Healthcare product specialist	Dedalus
Director of Digital Health & Nursing	Digital Health & Care Northern Ireland
Digital Nurse Practitioner	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Chief Nursing Information Officer	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Digital Nurse Practitioner	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
IT Clinical Lead	Dorset Health Care University NHS Foundation Trust
Clinical informatics practitioner	East Lancashire Hospitals NHS Trust
Community Nurse Specialist	East London NHS Foundation Trust
Chief Nursing Information Officer	East Sussex Healthcare NHS Trust
Deputy Chief Nurse	East Sussex Healthcare NHS Trust
National CNMIO	eHealth Ireland
Leadership Development Facilitator	Florence Nightingale Foundation
Chief Nursing Information Officer	Frimley Health NHS Foundation Trust
Head of Clinical Operations	HCA Healthcare UK
Safety Improvement Lead	Imperial College Healthcare NHS Trust
Clinical solutions manager / clinical safety officer	IMS Maxims
CSO	IMS Maxims
CLO / CSO	IMS Maxims
Practice Development Nurse	King's College Hospital NHS FT
PDN	Kingston Hospital NHS Foundation Trust
Chief Nursing Information Officer	Lancashire & South Cumbria NHS Foundation Trust
LMNS lead midwife	Lancashire and South Cumbria ICS
Chief Nursing Information Officer	Lancashire Teaching Hospitals NHS Foundation Trust
Programme Lead Paperlite	Lancashire Teaching Hospitals NHS Foundation Trust

Acute Medicine Therapy Service Lead	Lancashire Teaching Hospitals NHS Foundation Trust
Professor of Modelling	London South Bank University
Urology Nurse Practitioner	Maidstone and Tunbridge Wells NHS Trust
Lead Nurse for Falls Prevention	Maidstone and Tunbridge Wells NHS Trust
Practice Development Nurse	Maidstone and Tunbridge Wells NHS Trust
CNIO	Maidstone and Tunbridge Wells NHS Trust
Falls Prevention Practitioner	Maidstone and Tunbridge Wells NHS Trust
Lead IPC nurse	Maidstone and Tunbridge Wells NHS Trust
Digital Nurse	Manchester University NHS Foundation Trust
Digital Nurse	Manchester University NHS Foundation Trust
Matron-IPC	Manchester University NHS Foundation Trust
Lead Nurse - Digital Technology	Mersey and West Lancashire Teaching Hospitals NHS Trust
Chief Nursing Information Officer	Milton Keynes University Hospital NHS Foundation Trust
N/A	N/A
N/A	N/A
PPIE volunteer	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
N/A	N/A
Registered Nurse	N/A
Registered Nurse	N/A
Digital Health Specialist Nurse	Newcastle Hospitals NHS Foundation Trust
Pre assessment national advisor to GIRFT	Newcastle Hospitals NHS Foundation Trust
Nurse Consultant Digital	NHS Ayrshire and Arran/ Scottish Government
Clinical Informatics Specialist	NHS Digital
Clinical Lead	NHS Elect
Programme Manager	NHS England
Lead Clinical Safety Officer	NHS England

Nurse	NHS England
Clinical Lead	NHS Midlands and Lancashire CSU
Digital Nurse	NHS Nottingham University Hospitals NHS Trust
Digital nurse	NHS Nottingham University Hospitals NHS Trust
Digital nurse	NHS Nottingham University Hospitals NHS Trust
Digital Nurse	NHS Nottingham University Hospitals NHS Trust
Digital Matron	NHS Nottingham University Hospitals NHS Trust
Digital Nurse	NHS Nottingham University Hospitals NHS Trust
National safety and learning lead (GP)	NHS Resolution
Paediatric Clinical Informatics Nurse	NHS Wales
Digital Health Clinical Lead	Norfolk and Norwich University Hospitals NHS Foundation Trust
Chief Nursing Information Officer & Associate Chief Nursing Officer	North Bristol NHS Trust
CTS	North Bristol NHS Trust
Digital Nurse	North Bristol NHS Trust
Nurse consultant	North East London NHS Foundation Trust
Clinical digital transformation lead	North East London NHS Foundation Trust
Quality Lead Nurse	Northern Lincolnshire and Goole NHS Foundation Trust
Associate Director of Nursing	Northumbria Healthcare NHS Foundation Trust
Digital Nurse	Nottingham University Hospitals NHS Trust
Nurse Education Adviser	Nursing and Midwifery Council
Clinical Director	OHCP
Senior clinical consultant	Oracle
Lead Clinical Strategist	Oracle
Nurse Consultant	Oxford University Hospitals NHS Foundation Trust
operational and clinical lead for PH and treatment	Pennine Care NHS Foundation Trust
N/A	Pennine Care NHS Foundation Trust
Digital Change Health Practitioner	Princess Alexandra Hospital NHS Trust
Digital Health Change Practitioner	Princess Alexandra Hospital NHS Trust

Digital Change Health Practitioner	Princess Alexandra Hospital NHS Trust
Digital Health Change practitioner	Princess Alexandra Hospital NHS Trust
Head of Digital Transformation -Midlands	Princess Alexandra Hospital NHS Trust
MD	Quic
Lead Nurse RCN/Nursing Information Officer NHS	Royal College of Nursing
Lead Nurse for Quality, Safety and Innovation	Royal Cornwall Hospitals NHS Trust
Registered Nurse	Royal Free London
NIO	Royal Free London
N/A	Royal Free London NHS Foundation Trust
N/A	Royal Free London NHS Foundation Trust
Chief Nursing Information Officer	Sherwood Forest Hospitals NHS Foundation Trust
Chief Nursing Information Officer	Solent NHS Trust
Digital Practice Development Nurse	South Tyneside and Sunderland NHS Foundation Trust
Digital midwife	Southend University Hospital, Mid and South Essex NHS Foundation Trust
Clinical Nurse Specialist	St Richard’s Hospice
Digital Matron	Stockport NHS Foundation Trust
Digital Nurse	Stockport NHS Foundation Trust
EPR deployment lead	System C Healthcare
Digital Nurse Implementer	The Christie NHS Foundation Trust
N/A	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
Chief Nursing Information Officer	The Shrewsbury and Telford Hospital NHS Trust (SaTH)
Chief Nursing Information Officer	University Hospital Southampton NHS Foundation Trust
Digital Nurse	University Hospitals of Derby and Burton NHS FT
Endoscopy Manager	Warrington and Halton Hospitals NHS Foundation Trust

Patient Safety Improvement Nurse	Warrington and Halton Hospitals NHS Foundation Trust
Matron	Warrington and Halton Hospitals NHS Foundation Trust
Digital Lead Midwife	West Suffolk NHS Foundation Trust
Lead Nurse Digital Technology	Whiston Hospital
Principal Healthcare and Terminology Consultant	White Rose Healthcare
Director and Lead Clinical Architect	White Rose Healthcare Consulting Limited
Head of Clinical Applications	Wirral University Teaching Hospital NHS Foundation Trust
Chief Nursing Information Officer	Wirral University Teaching Hospital NHS Foundation Trust
Clinical Informatics Manager	Wrightington, Wigan and Leigh NHS Foundation Trust
Lead Nurse-Digital	Wye Valley NHS Trust

Table 5. *A table showing the role and organisation of attendees of the multidisciplinary webinar, when known.*

9 Appendix D - Supplier Webinar Attendees List

38 attendees, including PRSB and project team.

Role	Organisation
Head Of Communications, Engagement and Strategy	PRSB
Head Of Stakeholder Relations	PRSB
Project Manager	PRSB
Project Analyst	PRSB
Project Analyst	PRSB
Senior Business Analyst	PRSB
Chief Nursing Information Officer/ Clinical Lead	PRSB
Citizen Lead	PRSB (Citizen Lead)
Chief Nursing Information Officer	University College London Hospitals NHS Foundation Trust

Senior Project Manager	NHS England
Business Development	Camascope
Product Manager	Cegedim Rx
Head Of Clinical Safety	Cegedim Rx
Manager	Cura Systems
Clinical Safety Officer	Dedalus
Clinical Safety Officer	Dedalus
Healthcare Product Specialist	Dedalus
Healthcare Product Specialist	Dedalus
Change Lead At	Dedalus
Implementation Consultant	Dedalus
N/A	Department of Education (The Philippines)
Senior Clinical Informatics Practitioner	East Lancashire Hospitals NHS Trust
Deputy Chief Nursing Information Officer	East Suffolk and North Essex NHS Foundation Trust
CEO	FreshEHR
Data Service Manager	Humber Teaching NHS Foundation Trust
Physician Executive	InterSystems
Product Specialist	InterSystems
Physician Executive	InterSystems
Social Care Lead	Liquid Logic
Business Architect	Midlands Partnership NHS Foundation Trust
Clinical Informatics Nurse Specialist	NHS Wales
Digital Research Executive	Nourish Care
Clinical Lead	Nourish Care
IT Consultant	Oracle

Chairman - RCN: Digital Nursing Forum	Oracle
Chief Nursing Information Officer	System C Healthcare

Table 6. *A table showing the name and organisation of each attendee of the supplier webinar, when known.*

10 Appendix E - Digital Nursing Expert Review Workshop Attendees List

20 attendees, including PRSB and project team.

Role	Organisation
Transformation Lead for the Independent Health and Social Care Sector	Royal College of Nursing
Policy Director	National Care Forum
CNIO	Oxford University Hospitals NHS Foundation
Northwest Digital Nursing Lead	Lancashire & South Cumbria NHS Foundation Trust
Senior Clinical Lead	NHSE
CNIO	South Tyneside and Sunderland NHS Foundation Trust
Southeast Digital Nursing Lead	NHSE
Professional Lead	Royal College of Nursing
CNIO	Alder Hey Children's Hospital Trust
Southwest Digital Nursing Lead	NHSE
Programme Manager for Digital Medicines	NHSE
CNIO	Sherwood Forest Hospitals NHS Foundation Trust
Professor of Clinical Decision Making and Nurse	The University of Manchester
Interim CNIO	NHSE
Project Manager & Lead Analyst	PRSB
Project Analyst / Project Coordinator	PRSB
Project Analyst	PRSB
CNIO	UCLH
Senior Clinical Lead	NHSE
Standards Partnership Programme Lead Assessor and Nurse Advisor	PRSB

Table 7. A table showing the role and organisation of attendees of the Digital Nursing Expert Review Workshop.

11 Appendix F – Summary of Themes and of Element Changes Following Multidisciplinary Webinar

Theme	Attendee Comments	Comments / recommended actions
Electronic patient record alignment Some people commented that the data items should align with data items already in electronic patient records.	*"Data points need to be created with EPR [electronic patient record]."*	Local suppliers/ local implementations. NHS provides SNOMED codes, everything else is out of the standard remit. This is covered by local implementation decisions.
Concerns about use There were concerns that the standard was straying into specialist assessments rather than an initial assessment.	*"Should be an initial assessment and be mindful to not go into specialist assessments"*	Continue to remove elements that are not considered to be initial assessment.
Patient overview alignment Some had questions around whether coded data could be easily seen in the person's patient overview.	*"Will the linked/coded data be easy to see in a patient overview"*	Add recommendations for overview to implementation guidance.
Conformance concerns Attendees had questions regarding the conformance of certain data items in certain situations. There were concerns about mandatory items causing issues.	*"What consideration has been made to ensure only relevant data items are required"* *"There will be sections that are not required for every patient so as long as the fields are not mandated"*	Mandating data fields remains on a local stance, rather than nationally mandating. Data for direct care purposes is important for shared information. Consideration taken with conformance development.
Completion of sections where there are no problems If a patient has no issues in an area in the initial assessment, people wanted to know if the section could be satisfied quickly rather than manually completing each item.	*"Would section such as Nutrition and Hydration would only be applicable to patients who have these problems and can be satisfied as NA for patients who have no issues on nutrition?*	Advocate for use of normal limits. Incorporate within business rules. Allows system suppliers to be innovative and adhere to the provider needs.

Models of nursing There were concerns that different models of nursing were not considered when developing the model.	*"Models of nursing should guide the data we collect and how use is"*	Several models of nursing have been considered when developing the standard to ensure general alignment with current practices. Models of nursing are irrelevant to the minimum dataset; however, the data items should be mappable to any models of nursing. This is down to local implementation.
Cross over with other assessments Some attendees had questions around how the standard will cross over with other assessments used by nurses and other health care professionals.	*"Will the allied health professionals' assessment be using the same structure. Unhelpful if nursing and physio assessment of mobility is in different places/different structure. Similarly, nutrition with dietetics. They might have different data points, but also a lot of cross over."*	Conversation to be conducted in future phases. Specialisms are not within the remit of the Nursing Care Needs Standard. Responsibility of local system suppliers to ensure that the cross over does not occur.
Having a multi-professional document There was discussion that naming the record the Nursing Care Needs Standard could be limiting, and that approaching it as a multi-professional document would be beneficial.	*"Maybe not call it a nursing documentation standard but a patient documentation standard so everyone, all professionals feel they can access this"* *"Agree that patient function standard (or whatever) better that nursing, so other professions use it too."*	This is out of scope for the current project, as this focuses on nurses' initial assessment.
Terminology There were many concerns about the frequency of free text options, and the lack of SNOMED coding. Multiple comments highlighted the importance of SNOMED and utilising it in this standard.	*"You say "data items" yet they are headings, ergo carry no meaning (from a machine perspective). How will you deliver standard data without recourse to SNOMED CT or what other vocabularies are you proposing (hint there is no choice here)"* *"Problems: likely way too much free text = data loss ergo little value"*	We will engage contact with NHSE terminology experts to ensure that the correct SNOMED coding is used for each element, whilst also aiming to reduce the amount of mandatory free text that nurses will have to input.

Poor quality nursing data There were concerns about the data not driving patient centred care, and instead increasing the "taskification" of care for nurses.	*"Taskification of care and atheoretical lists make it hard to relate to outcomes"* *"Repeated assessments aren't helpful, the data needs to drive patient centred goals and content of care planning"*	This project standardises assessments already being conducted by nurses and should not increase workload for users. Continue to reduce the number of elements that nurses must record to reduce amount of data. Continue to consult with nurses to ensure data is patient centred.
Quantity of data There were concerns around how many data items were in each section of the initial assessment, and how this could increase burden for nurses rather than reduce it.	*"Too much data to capture for every patient a nurse has, unrealistic and burdensome"* *"We capture massive amounts of data now but most of it is in paper and not used very well"* *"We need to try and reduce the documentation burden, not increase it."*	This was an important element for many attendees. This project standardises assessments already being conducted by nurses and should not increase workload for users. To reduce the data burden: remove any unnecessary items; combine data items that can be easily paired; utilise the value set to allow multiple data to be captured within one element. Furthermore, we will recommend areas for autocompletion based on the person's EPR.
Duplication of data Several people voiced concerns around the duplication of data both within the standard, and with other records.	*"Need to make sure the data is pulled through from other sections so data does not need to be replicated"*	We will continue to assess the current standard to ensure that items are not duplicated across different sections. Implementation guidance will highlight areas where previously input information can be carried through.
Missing areas Some areas that are typically assessed by nurses were brought up as they were not covered in the standard.	*"No standards on communication, breathing, sleeping/rest, etc?"*	We have consulted with NHSE about what is in and out of scope for the standard, and we will not be able to include these additional sections during this phase.

Table 8. *A table showing key themes from the multidisciplinary webinar, and the recommendations on how PRSB addressed these themes.*

Section	Recommended actions
Eating and Drinking	The following items have been renamed: • Problem(s) with drinking fluids (renamed) • Sensory preferences (renamed) • Dietary requirements (renamed) Add the following data items: • Eating and drinking capability Remove the following data items: • Date first experienced dehydration • Mouth health • Exemption from NHS dental charges • Eat alone or with others • Appetite • Breastfeeding status
Mobility	The following items have been renamed: • Mobility aid dependency (renamed) • Footwear, hosiery, and care (renamed) Add the following data items: • Number of staff required to assist with mobilisation • Falls and balance • Use of cot sides • Observed delirium • Observed frailty • Comments Remove the following data items: • Mobility status assessment • Transfer support • Lateral transfers • Is the person able to climb stairs safely? • Is the person sufficiently mobile to access local shops? • Approximate distance individual travels to the shop • Is the person able to get out of a standard vehicle? • How does the person normally get to school/college/work? • Does the nurse consider the person to be unsteady when mobilising?
Elimination	Add the following data items: • Elimination capability • Typicality of bowel problem • Typicality of urination problem • Comments

	Remove the following data items: • Are these problems within the boundaries for normal child development for the person? • Are these problems typical for the individual? • Elimination specialist involvement
Personal Hygiene and Dressing	Add the following data items: • Nail hygiene • Expected level of personal hygiene and dressing capability for children (in line with developmental stage) • Normal routine for personal hygiene and dressing at home • Equipment that the person has brought with them for personal hygiene and dressing • Preferences (including clothing, bath/shower, product, carer gender, and general) • Problems affecting personal hygiene and dressing • Shaving • Personal hygiene and dressing capability • Level of support needed • Equipment needed to support personal hygiene and dressing • Religious/cultural considerations • Comments • Impact of medications on personal hygiene and dressing Removed the data item “ability to manage buttons.”
Skin	Skin integrity has been reduced to one item, which will include multiple SNOMED-CT codes that can be used to capture a variety of potential issues with skin integrity. There was a lot of feedback about the PRSB wound care standard making this section superfluous. We have aligned ourselves with this standard to capture the necessary information and any other initial assessment skin needs not captured by this standard. Add the following data items: • Skin integrity • Ability of person to alter their own position • Devices affecting skin • Footwear/clothing effect on skin • Medication affecting skin • Medication name • Comments Removed the following data items: • Skin quality • Hydration level of skin • Bruise(s) • Swelling • Skin history

Medication Self-Management	"Desire to self-administer medication" changed to "ability to self-administer medication." Add the following item: • Comments Remove: • Does the patient have their medication with them? • Desire to self-administer • As in-patient • At home • Potential difficulties with self-administration • Medication management plan • Medication organisation equipment • Preferred form of medication • Medication review requested • Non-prescribed medication(s)

Table 9. *A table summarising the changes to the data model at the section level, following feedback from the multidisciplinary webinar.*

12 Appendix G – Summary of Themes from Supplier Webinar

Theme	Attendee Comments	Recommendations
System capabilities vs. usage	*"From a systems point of view, I'm sure everyone's systems are capable of recording things. You know these items, but obviously the trusts are not choosing to use it like that or have got their assessment design in particular way."*	Promote collaboration through workshops and training for healthcare providers and suppliers. Highlight benefits like streamlined processes and improved patient care to drive adoption of supplier systems and digital standards.
Resistance to digital adoption	*"we've still got quite a lot of senior nurses out there who are in maybe chief nurses, whatever, who quite analogue folk and don't really understand the Potential benefits of digital. So, there is a massive piece of work there to help them."* *"That is the premise behind the London and similar Universal Care Plan - record once in a patient-centric record, that is appropriately widely available."*	Address the unique workflows and responsibilities of Nursing, highlighting how digital tools can enhance efficiency, accuracy, and patient care. Offer ongoing support through dedicated help desks or mentors to address any challenges they encounter during the transition.
Other nursing models	*"Will the data items be mapped to a clinical terminology like SNOMED?"*	Conduct a comprehensive review of the other nursing models, e.g., Dutch ZIBs

	"ZIBS [Zorginformatiebouwstenen] has SNOMED coded where possible"	model, that utilises SNOMED CT terminology. Verify the accuracy of terminology mapping, ensure semantic and logical consistency, and evaluate concept coverage.

Table 10. *A table showing key themes from the supplier webinar, and the recommendations on how PRSB addressed these themes.*

13 Appendix H – Summary of Feedback from the Digital Nursing Expert Review Workshop

Theme	Recommendations
Implementation and Clinical Clarity	Emphasise the balance between implementing standards and maintaining clinical data clarity.
Assessment-Planning-Implementation	Follow the assess-plan-implement cycle for effective care.
Public Health Versus Community	Differentiate between public health and community contexts, using standards appropriately.
Professional Judgement	Empower nurses to exercise professional judgement when applying standards.
Usefulness of Risk Assessment	Evaluate the practical use of risk assessment in practice.
Standardization and Information	Focus on standardising information collection for consistent data.
Digital Information Capture	Embrace digital methods for capturing and transmitting coded clinical data.
Project Remit and Minimum Dataset	Define the project's scope and establish a minimum dataset of clinical information.

Table 11. *A table showing key themes from the Digital Nursing Expert Review Workshop, and the recommendations on how PRSB addressed these themes.*

Section	Theme	Recommendations
Eating and drinking	Duplication of data items & weight loss:	Specific assessments are outside the remit of this development phase. However, it is the responsibility of the local implementors that significant weight loss should prompt a MUST (Malnutrition Universal Screening Tool) assessment.

	Food allergies:	Allergies are included in the standard; they are inherited via the CIS. Therefore, they are not included in the eating and drinking section.
	Tube feeding methods (TFM):	Utilise SNOMED coding for tube feeding methods and titration.
Mobility	Risk assessment:	Risk assessments are outside the remit of this development phase. However, the use multifactorial risk assessment, incorporating NICE guidelines and broader literature can fully empower the provider to utilise their clinical judgement.
	Falls assessment:	Falls assessment are outside the remit of this development phase. There is only a validated falls assessment primarily applicable in the community setting.
	Transferring and Movement:	Consider core strength, medical conditions, and changes in mobility; refer to physiotherapy when necessary.
	Baseline vs. Admission vs. Discharge Mobility:	Recognise differences in mobility at various stages of care; however, this standard is intended only at initial assessment. Repeated measures assessment is outside the remit of this development phase.
	Paediatric considerations:	Address unique mobility challenges in children.
Elimination (Toileting and continence)	Catheters:	Distinguish between long-term and short-term catheters, include relevant dates.
	Catheter passport:	Consider the presence of a catheter passport, if applicable. This was agreed to be out of the remit of initial assessment.
	Menstruation:	Capture female self-care, hygiene, and menstrual considerations.
Personal hygiene and dressing	Capability and Problems duplication of data items:	Assess personal hygiene and dressing capabilities and issues.
	Medication impact:	Include medication-related complications affecting hygiene and dressing.
	Medical devices:	Account for medical devices related to eyes and ears, accommodating individual needs. This information will be captured via the inherited CIS sections – Individual requirements, therefore it is

		not included in personal hygiene and dressing section.

Table 12. *A table summarising the feedback and recommendations from the Digital Nursing Expert Review workshop.*

14 Appendix I - Survey Report

Find the link to the Nursing Care Needs Standard Survey Report **here**.