The National Quality Forum

Comments on Draft Report: National Voluntary Consensus Standards for

Developing a Framework for Measuring Quality for Prevention and Management of Pressure Ulcers

#	Member Council/ Public	Organization Contact	Topic ID	Topic	Comment	Proposed Action
242	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.1 Staging of Pressure Ulcers The NQF proposal to eliminate staging is disputed by NPUAP. The term stage is and has been used to define and describe the amount of visible tissue loss. While people do consider the stage of a pressure ulcer along a linear trajectory; having defined the problem of deep tissue injury NPUAP is well aware of the contrast in etiologies both from the outside in and the inside out. We cannot see an advantage to using the term "grade" because it also implies linear movement. NPUAP actually addressed the issue of the word "stage" last year. While writing the new international guidelines, the words "stage" and "grade" were replaced with a new word "category" for the implication of progression of the ulcer. However, when the NPUAP board examined the proposed change to the term "category", it was not recommended due to the confusion with the new ICD-10 codes and the present on admission rule. The current present on admission rule does not allow payment for unstageable pressure ulcers. Therefore if hospitals are going to try to claim an ulcer is present on admission, it must be classified by stage. A "full thickness" ulcer would not trigger the proper ICD-9 code for payment. The current staging system is reliable and improves communication between disciplines, allows allocation of preventive and treatment surfaces and prescription of topical treatments. The information also allows for comparison of data between settings, between patient types and between care delivery systems. Nixon and colleagues (2005) reported on a study of pressure ulcer assessment between general registered nurses and wound nurses. In this study, in addition to the usual categories of pressure ulcers, there was also a classification for blanching or nonblanching. Interrater reliability was high; there were 21% disagreements and 82% of the disagreements were within one grade. Bours and colleagues (1999) compared nurses' and wound care experts' bedside assessments of pressure ulcer grading in a variety of healthcare settings. The nurses in the hospital and nursing home had near perfect interrater reliability (IRR) (0.97 and 0.81). IRR was lower in the home setting (0.49).	To date, there is little definitive evidence beyond consensus or small studies as to what are best practices in pressure ulcer measurement and treatment. This report provides proposed guidance regarding potential revisions to current pressure ulcer care that will add clarity and additional detail for caregivers in order to standardize the optimum details of measurement and best practices of treatment. It is intended to focus future research to provide definitive data as to what methods are effective and therefore positively impact the quality of care and quality of life of the patient/client/resident.
178	Member, Consumer	Debra Ness, National Partnership for Women and Families	2	Domain 1: Measuring and Staging Pressure Ulcers		

176		Debra Ness, National Partnership for Women and Families	2	Domain 1: Measuring and Staging Pressure Ulcers	The proposed change from the term “stage” to a two-part classification is also faulty: 1) While staging is difficult, it is not impossible. Adequate training in staging and differential diagnosis is required. 2) Plans of care are based on the stage. The treatment of a stage I does not equal the treatment of a stage II. Stage II ulcers are dressed or covered. Stage I pressure ulcers require no topical treatment. Adding the term “open” or “closed” to the partial thickness label is the same term as stage I and stage II. If the phrase “partial thickness” were used, how would the quality of care provided be judged? It would appear that the inappropriate treatment to a stage II, that is letting it dry out, would be correct if the ulcer were a stage I. Stage I and II ulcers heal; the tissue replaced is the same as the tissue lost. Epithelial and dermal tissues are regenerative. The word “closed” should be reserved for ulcers that require contracture and scar. The treatment of a stage III is not the same as a stage IV, nor is it the same as the treatment for an unstageable ulcer or Deep Tissue Injury (DTI). The proposal recommends using the word “closed” to signify a healed state; we agree because biologically these ulcers never “heal” and are subject to future breakdown. Using the proposed words “closed” to distinguish DTI and unstageable from “open” stage III and IV is also faulty. Again, how could the quality of care be judged when the ulcer is labeled as a closed full thickness pressure ulcer? What if the ulcer was débrided? DTI should not be débrided; some unstageable ulcers should not be débrided. Deep tissue injury can be rescued, and if it were lost in the nomenclature of “full thickness”, the clinical science of DTI would be lost. Using the term “deep structure involvement” says little. Again, could quality standards be applied to this label?	
159	Member, Consumer	Carol Sakala, Childbirth Connection	2	Domain 1: Measuring and Staging Pressure Ulcers	NPUAP can see no benefit to simplifying the staging system. The combined work of the NPUAP and our European colleagues (EPUAP) over the past 3 years has resulted in the development of an international classification system that is based on	

154	Member, Health Professionals	Lea Anne Gardner RN PhD (on behalf of the Performance Measurement Subcommittee), American College of Physicians	2	Domain 1: Measuring and Staging Pressure Ulcers	decades of basic science (histology), clinical use, and results of educational initiatives that improve inter rater reliability. We have made great progress in achieving international agreement based on available scientific evidence and expert input. Treatments are clearly distinct for different stages/grades/categories of ulcers. The EPUAP-NPUAP guideline was reviewed by 950 stakeholders in 53 countries on 6 of the 7 continents. This broad base of support should give us "pause" before changing the current internationally accepted classification system for pressure ulcers to a full-thickness vs partial thickness dichotomy that is untested. If the terms NQF proposes were to be used, we do not see how it clarifies communication. In an effort to simplify, the diagnostic labels would be unclear and not drive clinical care. As other nomenclatures have developed and been refined, they become increasingly distinct. For example, right and left sided heart failure was the old categorization where today, heart failure is classified as left ventricular systolic failure and other similar diagnostic labels.	
119	Member, Purchaser	Shari Ling, CMS/OCSQ/QMHAG	2	Domain 1: Measuring and Staging Pressure Ulcers		
113	Member, Purchaser	Gaye Fortner, HealthCare 21 Business Coalition	2	Domain 1: Measuring and Staging Pressure Ulcers		
74	Public	Deborah Baehser, Cape Regional Medical Center	2	Domain 1: Measuring and Staging Pressure Ulcers		

189	Member, Provider	Jennifer Faerberg, AAMC	1	General comments on the report		
38	Public	Mary Farren, VNSNY	2	Domain 1: Measuring and Staging Pressure Ulcers	Staging versus Grading: I believe there will be more confusion with a "Grading System" particularly in the assessment of "darkly pigmeneted skin" The definitions between a Stage One and a DTI Under the Staging System are very similar ... difficult to detect..painful, soft , firm, warm, cool etc. If these definitions are moved into a "Grading system" - a stage one will be "partial thickness" and a DTI will be "full thickness" .. which may have implications yet to be recognized in quality measures and in other areas including reimbursement.	The framework provides guidance to measure developers and those who implement standards into their systems as to where future change may need to occur. It provides researchers an opportunity to develop field testing as to the clinical impact as well as the business case to support the changes. With any change in process it is expected there would be costs incurred to update payment systems, documentation, and to provide training to both users at the bedside and at the oversight/payment related organizations. Current or pending instruments such the Minimum Data System (MDS) 3.0 and Outcomes and Assessment Information Set (OASIS) C would not expected to incorporate these recommendations since it would impede their roll out in order to do further testing of the proposed revisions. It is understood that any evidenced based changes that can impact payment or survey systems must be implemented over time, especially in the case of
118	Member, Purchaser	Shari Ling, CMS/OCSQ/QMHAG	1	General comments on the report	We agree that a framework for the Measurement of, Prevention and Management of Pressure Ulcers lays the foundation for a common language that should translate into improved quality across all care settings. We also agree with the notions set forth to promote ideal physiologic conditions to maximize healing of existing pressure ulcers and the prevention of new ones. However, the extent to which the proposed framework is aligned with pressure ulcer definitions, concepts, preferred practices and time-frames endorsed by other professional organizations (NPUAP, WOCN, Nursing associations) should be clarified. Furthermore, although the stated purpose of the framework is, in part, to help guide identification and organization of NQF-endorsed preferred practices and measures to address, it would be extraordinarily helpful to also articulate the anticipated consequences of implementation for patient care, reporting and accountability across all care settings. Likewise, CMS will need to further evaluate the content of the Pressure Ulcer Framework, including the three specified domains and 8-hour time-frame; due to the broad impact endorsement could have on current quality measures, survey and certification processes, payment policies and regulatory impact across the care continuum.	

130	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	2	Domain 1: Measuring and Staging Pressure Ulcers	Overall, Mayo Clinic does support simplifying current staging to full and partial thickness injury pressure ulcer. This change will decrease the chances of getting the grade of a pressure ulcer wrong as there are only 2 to pick from rather than 6 stages. However, there are some issues and concerns with this grading system:Will this grading system capture the description of the pressure ulcer in enough detail, including severity? With the current staging, you have a good idea of what the pressure ulcer is before you see it. However, it may be beneficial in that it might force the provider to describe the wound rather than rely on the staging system for assumed description.In the Bryant and Nix textbook Acute & Chronic Wounds, 3rd edition, partial thickness wounds are defined as a loss of epidermis and possible partial loss of dermis. With this definition, Stage I would not fit into this category as skin is intact.Educational resources (in many systems) will be needed to re-educate as we are continually educating with current staging system.Medical record changes (electronic in many organizations) will also need to occur. Would there be benefit to trialing this before moving forward to see impact on hospital systems?	The framework provides guidance to measure developers and those who implement standards into their systems as to where future change may need to occur. It provides researchers an opportunity to develop field testing as to the clinical impact as well as the business case to support the changes. With any change in process it is expected there would be costs incurred to update payment systems, documentation, and to provide training to both users at the bedside and at the oversight/payment related organizations. Current or pending instruments such the Minimum Data System (MDS) 3.0 and Outcomes and Assessment Information Set (OASIS) C would not expected to incorporate these recommendations since it would impede their roll out in order to do further testing of the proposed revisions. It is understood that any evidenced based changes that can impact payment
191	Member, Provider	Belinda Ireland, BJC HealthCare	1	General comments on the report	This is a well described, extensively researched and documented framework highlighting the important domains and sub-domains required to achieve the goal of measuring quality around prevention and management of pressure ulcers and the committee and NQF staff are to be commended for their work. We support the framework and the need for standardization.	Thank you for your comment.
198	Member, Health Professionals	Caitlin Connolly, American Geriatrics Society	1	General comments on the report	Other than these specific comments, we find the entire draft of a quality that deserves support.	Thank you for your comment.
210	Member, Provider	Lee Ann Krapfl, Mercy Medical Center	1	General comments on the report	I would recommend adding a statement that suggests regular wound measurement be performed be a consistent caregiver in settings where there is reasonable. Pressure ulcers do not heal in a predictable manner. Different measurements from different clinicians only adds to the inaccuruarcy of this parameter. This is antidotal observation, but I find that the 'box' method is the easiest to teach others. The framework should capture measures that promote consistency across all care settings.	Thank you for your comment.

214	Public	Teresa M. Mota, Quality Partners of Rhode Island	1	General comments on the report	Hello, The QIO program conducted a National Nursing Home Improvement collaborative related to Pressure Ulcer Prevention and Treatment and published results in JAGS. The discussion and data may be of some use related to process, analytics, etc. Thank you. Lynnn, J., West, J., Hausmann, S., et al. (2007). Quality improvement for pressure ulcers. JAGS; 55(10): 1663-1669. Taler, G. (2007). Editorial. A clarion call to rethink pressure ulcers in america. JAGS; 55(10): 1674-1675.	Thank you for your comment.
217	Member, Purchaser	Jennifer L. Eames, Pacific Business Group on Health	1	General comments on the report	We think there should be a greater emphasis in the framework on using outcomes to measure performance. Examples include measuring incidence (and not prevalence) of pressure ulcers, as well as how they were treated and how long it took the patient to get well. To truly have an impact on improving care, it should also be noted that any process measure brought forth should be linked to outcomes.	Thank you for your comment.
219	Member, Health Plan	Jed Weissberg, Kaiser Permanente	1	General comments on the report	NQF's efforts to develop a framework for the prevention and management of pressure ulcers across the continuum are commendable. Kaiser Permanente firmly agrees with the crucial focus to support effective care transitions for patient-centered outcomes and therefore, the vital need for the harmonization of measure specifications across care settings. As a large health care system, any system to simplify and clarify that is endorsed by wound care experts is helpful. However, we also have concerns since the proposed change in the naming system from staging to a grading process calls for extensive rebuilding of current systems, including treatment modalities, nomenclature for pressure ulcers, algorithms, electronic health records and physician order sets, along with training and education for nursing and physicians. Furthermore, NQF will continue to roll out its 15 Nursing-Sensitive measures, which also requires attention and resources. Given numerous priorities, the proposed grading process may divert scarce resources away from prevention and intervention to rebuilding widespread systems and ensuring an infrastructure with adequate timing to support this change. Therefore, Kaiser Permanente recommends more NQF discussions with key stakeholder groups across the care continuum before any changes are made, along with alignment with other organizations that also provide standards for reporting, as well as a gradual introduction if this proposal goes forward.	NQF understands a gradual transition period will be necessary if this framework is endorsed.

237		Ellen L. Williams, HealthCare Education Solutions, Inc.	1	General comments on the report	1. Line 257 – Domain 1, Is it appropriate in this forum to define/state who may stage pressure ulcers? 2. Line 342 – Domain 1.2 – Measure Length-Head to Toe orientation for ease of teaching clinicians who may not be wound mgt proficient and for consistency, Width – longest measure perpendicular to length, Depth – deepest deficit within wound, with tunneling/undermining as separate measurements using clock face for orientation within wound bed, Composite – using length A 3. Line 373-377 – include exudate type, not amount, using continuum from purulent to serous 4. Line 477 – Domain 2.2 recommend assessment training for P&I teams immediately prior to P&I study 5. Line 493 – Fully, Fully agree 6. Line 537 – for patients who are hemodynamic ally unstable (ER, CC), can concessions be made for them? 7. Line 541 – 8 hours is too long, the skin assessment can be included with the admission assessment within the first 2 hours of admission 8. Line 545 – have a communication plan that triggers the different components of the interdisciplinary plan of care so that plan may be developed and implemented within the first 24 hours 9. Line 667 – Domain 3.7 – WTD? Can that be totally removed? Define what is considered long term vs short term therapy. 10. Line 667 – NPWT reference 9 – only refers to open cell foam dressings. With the proliferation of NPWT companies using other tissue interface media, can it not be specific to open cell foam?….too product specific.	1. It is not appropriate in this forum to define/state who may stage pressure ulcers 2, 3, 4, 5, 8. Thank you for your comment 6. Patient characteristics should be taken into account - head-to-toe skin assessment should be done within 6 to 8 hours. 7. NQF recommends the head-to-toe skin assessment be completed as soon as possible but no longer than 6-8 hours upon arrival to the facility. In home health, NQF recommends the assessment be performed on the first visit. 9. The Steering Committee stated there may be circumstances where wet-to-dry dressings may be appropriate. Long-term therapy is defined in the report as acute presentation, or acute periooperative period or while transitioning from one therapy to another after an acute deterioration or change in the status of the wound.
241	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	1	General comments on the report	This letter addresses the proposed changes in pressure ulcer nomenclature and the measurement of pressure ulcer data, both through the size of the ulcer and prevalence and incidence of pressure ulcers. However, before getting to the specifics, we offer some general observations. Some rather broad statements are made in the document that imply a comprehensive review of the literature underpins this document. Statements such as “studies have shown” and “there is no evidence that….” lead the reader to believe that a comprehensive review of literature was completed. Statements are not supported by citations. Some statements are erroneous and misstate the existing scientific evidence. We understand that some evidence was available to the group; however, it does not appear to be a comprehensive review. NPUAP would be happy to share the results of a 3-year international comprehensive literature review on pressure ulcer prevention and treatment.	Thank you for your comment.

257	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	1	General comments on the report	Research Needs NPUAP supports the need for research in all domains surrounding pressure ulcers. We find it ironic that the first research need listed in this NQF document is technology to help with pressure ulcer staging, when the NQF wants to eliminate staging. Thank you for allowing us to comment on the NQF document.	Thank you for your comment. The term staging has been replaced by the term categories throughout the report. Using the term categories aligns with the NPUAP's guidelines.
257	Member, Health Professionals	As requested in the report our comments regarding the three methods of pressure ulcer measurement are outlined below.	1	General comments on the report	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) National Voluntary Consensus Standards for Developing a Framework for Measuring Quality for Prevention and Management for Pressure Ulcers report. We support this proposed framework and its quality measurement components for the management and prevention of pressure ulcers. This report serves a critical purpose to raise the standard of care and further advance the effectiveness of care provided to this vulnerable patient population.	Thank you for your comment.
14	Public	Denise Elber, Parma Hospital	2	Domain 1: Measuring and Staging Pressure Ulcers	Understand the recommended changes. Simplifies the process, understanding. Would require additional information related wound base obsrvation. How would this change affect current CMS changes, current national prevalence studies and so forth as currently incorporates Staging? Question stems from not understanding the impact of the Quality Forums final recommendations.	See comment # 219.
29	Member, Provider	Holly Kirkland-Walsh, University of California Davis Medical Center	2	Domain 1: Measuring and Staging Pressure Ulcers	Measuring pressure ulcers should be standardized and kept to a minimal number of measurements. Most facilities have adopted photography to facilitate their measurements and description, I think we should use technology to enhance our communication across the care continuum. A photo with measurements and current treatment should be sent with patients on discharge to SNF, clinics, and home health care.The staging should be changed to partial thickness and full thickness. The current staging system creates chaos in a teaching facility.	Thank you for your comment.
32	Public	Kathleen Francis, Visiting Nurse Service of NY	2	Domain 1: Measuring and Staging Pressure Ulcers	I do not agree that the terminology regarding staging should be revised or changed to a grading system. Your argument related to staging not linked to treatments or outcomes does not support the change. If we change the verbiage to a grading system, the issue of treatment and outcomes remains. In addition, any such change would require tremendous re-education effort. The issue should be the implementation of the same staging system & guidelines across the continuum so that the accurate identification of ulcers can be achieved. Only with the accurate staging, assessment, & identification of the wound can an appropriate plan of care be implemented.	Due to the current inappropriate use of staging of pressure ulcers at the bedside, the new proposed categories of pressure ulcers will enable caregivers to more accurately categorize PU and collect data.

33	Public	Kathleen Francis, Visiting Nurse Service of NY	2	Domain 1: Measuring and Staging Pressure Ulcers	Line 286- The Partial thickness issue. The NUAP answered this one when they changed the descriptions/definitions. There is some literature out there that discusses the fact that stage 1 pressure ulcers that are non-blanchable are ischemic and therefore are more serious (why we status them as not-healing) than blanchable errythema. Some early literature described both blanchable & non-blanchable and this is the basis for the partial thickness description. I think that areas of errythema that persist after offloading are being documented as St I across the continuum. So, unless they are discussing adding an additional stage for the blanchable errythema, the partial thickness definition is inappropriate. Line 301 Yes closed is a better term.	Thank you for your comment.
35	Public	Yanick Martelly-Kebreau, Visiting Nurse Service of NY	2	Domain 1: Measuring and Staging Pressure Ulcers	The report proposes adopting the European classification of pressure ulcers that is grading instead of staging these wounds. Such change would require a lot of work with re-educating clinicians and changing paper and electronic documentation through out all facilities and the reason cited in the report does not support such effort. I searched the literature and found that this European grading system does not address deep tissue injury and unstageable pressure ulcers; if we adopt this classification, these stages/grades would need to be addressed. I believe the problem is with correctly identifying tissue types when structures such as bone or tendon are not exposed; differentiating between a stage III and IV can be challenging when these structures are not observed. Because of this, I would support classifying pressure ulcers as partial or full-thickness wounds. 286- I do not believe we can objectively say that a stage I is a partial thickness injury. 301- I agree that the term closed instead of healed should be used for stage III and IV pressure ulcers since a full thickness injury is always at risk for breakdown.	The framework proposes including deep tissue injury and 'unstageable' pressure ulcers in the full thickness injury category.
39	Public	Mary Farren, VNSNY	2	Domain 1: Measuring and Staging Pressure Ulcers	Line 301 - consider instead of Closed or healed... a statement that states the skin is now "intact" Line 352-359 - regrading measurement we include the position patient is in when wound is measured - it aids in obtaining consistent measurements.	Thank you for your comment.
41	Member, Provider	Donald Casey, Atlantic Health	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.1 Agree with the following: Using a grading verses a staging system to classify pressure ulcers. Identify Stage II as partial-thickness and Stage III-IV as full-thickness. The term closed verses healing when wound has fully epithelialzed. With the evidence that staging does not support the concept of the progression in pressure ulcers Disagree. Disagree-with the labeling of Stage I as partial-thickness	Injury to the tissue may occur from the inside out therefore a break in the skin may not occur.
42	Member, Provider	Donald Casey, Atlantic Health	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.2 Agree -The box technique for measuring wounds: The longest dimension, regardless of the orientation. The grading system would better suite pressure ulcers and would better accommodate the newer stages (ie; DTI and Unstageable). In this process the terms of closed and healed are not clear and how would you accurately describe pressure ulcers that recur on the same spot if you are not using the term healed or resolved This step is not clear in this document and could be confusing for the average staff nurse whom the system is being utilized by. Best area method is the most accommodating and fundamentally sensible.	Thank you for your comment.

44	Member, Provider	Donald Casey, Atlantic Health	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.4 Agree with number two, the most severe pressure ulcer should be reported. Unsure how changing wording will impact on more accurate labeling. Darker pigmented skin will still be difficult to assess as will areas without underlying bone. Non-blanchable skin and blisters or shallow craters will still herald tissue destruction. Treatment of pressure related wounds is related to its stage and we agree it is not related to outcome. The definitions of the partial thickness and full thickness injuries are more inclusive than those from previous Staging; therefore we think they are clearer. I could be convinced that it is a better method of labeling. I also like the healed vs.closed distinction. Measuring has always been very challenging, so standardization would be wonderful. In Homecare we use Digital Documentation a great deal. It is very difficult to assess changes from photographs taken of same wound from different angles, by different clinicians, with different camera phones all with varying levels of expertise in photography, and have no point of reference within the photograph. After viewing TALER power point, I would choose "B" Best Area longest measurement within the boundaries of the wound. I would also support use of some method of standardization of labeling that also provides an anatomical orientation.	Thank you for your comment.
65	Public	Angela Stokes, Truman Medical Center	2	Domain 1: Measuring and Staging Pressure Ulcers	I like the changing of the staging guidelines to partial and full thickness. Even with the educational efforts to update staff on the new staging guidelines, it has been challenging to ensure that staging is consisent across shifts and throughout the continuum of care. 2 grades would simplify the process.	Thank you for your comment.
68	Public	Julia Powell, National HealthCare Corp	2	Domain 1: Measuring and Staging Pressure Ulcers	Since photographs between sites of care may vary considerably (different camera, different lighting, different photographer etc.), it would not seem prudent to use them. I would opt for choice B in the measurement methods proposed by Dr. Taler.	Thank you for your comment.
80	Member, Health Professionals	Rita Munley Gallagher, PhD, RN, American Nurses Association	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.2The American Nurses Association (ANA) recommends that wounds be measured in a head-to-toe direction, encompassing the wound; with the width being construed as the longest perpendicular and the depth as the deepest site to the plane of the wound surface at the level of the skin.	Thank you for your comment.

83	Member, Provider	Laura Bolton, AAWC	2	Domain 1: Measuring and Staging Pressure Ulcers	Many thanks to the National Quality Forum for improving and unifying quality measures for pressure ulcer measurement, prevention and management. This is to respond to your request for comments on pressure ulcer area measurement recommending longest axis of the wound as length, longest perpendicular to length as width and deepest perpendicular to the plane of the ulcer surface as depth. Please accept these geometric definitions in the explanation below as I was unclear how to reconcile them with Dr. Taler's presentation definitions. Percent reduction in pressure ulcer area after two weeks of care can identify a non-healing pressure ulcer (1) before it deteriorates seriously. Kantor and Margolis (2) showed that percent area reduction can be calculated simply based on geometric longest length x longest perpendicular width measurements and confirmed its optimal predictive and discriminative validity in identifying non-healing wounds plus construct validity and reliability in estimating planimetric wound area reduction in a clinical cohort of 260 patients. Traditions like body axis ulcer measurement are hard to give up, but it may be worth it for the earlier capacity to identify a non-healing ulcer. Please see next boxes for validation and evidence referenced. Thank you.	Thank you for your comment
84	Member, Provider	Laura Bolton, AAWC	2	Domain 1: Measuring and Staging Pressure Ulcers	Wound area and percent contraction estimated from geometric length and width measurements are reportedly more reliable than those based on body axes (3) and not subject to the added error of measurement over time during clinical use as wounds change in shape and orientation along the body axis during healing. No matter how an ulcer is oriented on the body axis, its longest length and width are still its longest geometric length and longest perpendicular width. Always using geometric length and width would avoid confusion and variability of deciding when anatomical structures are not available for head-to-toe measurement. (Page 9, line 359), allowing consistent uniform mathematically accurate simple measures on which to base area estimates for all pressure ulcer patients all the time. The suggestion (page 9, line 334) that geometric length and width are more prone to patient and skin manipulation variation than body axis length and width seems unrealistic. Length and width measurements depend on patient and skin manipulation no matter how they are measured. Please continue with conclusion and evidence next boxes.	Thank you for your comment.

85	Member, Provider	Laura Bolton, AAWC	2	Domain 1: Measuring and Staging Pressure Ulcers	Consistent, accurate geometric length and width measurements enable professionals to estimate wound area accurately and reliably in to: -Benchmark wound progress across the continuum of care (4) -Optimize clinical feedback about wound progress and wound healing outcomes (5) -Monitor progress to meet government requirements (6) such as F-Tag 314 -Communicate progress to patient, family or other professionals -Implement early action to improve diagnosis or care for a non-responding ulcer (7-10) In conclusion, whatever the goal of wound measurement, area or percent change in wound area over time (based on longest length x longest perpendicular width wound measurements) is an evidence-based option in which those using a ruler can be confident. Multiplying this by deepest perpendicular depth yields a consistent geometric estimate of volume. Substantial clinical evidence supports reliability and validity of using these simple measures to track wounds across the continuum of care and provide feedback to keep patients on the path toward healing. References 1.Van Rijswijk L, Polansky M. Predictors of time to healing deep pressure ulcers. Wounds 1994; 6(5): 159-165. 2.Kantor J, Margolis DJ. Efficacy and prognostic value of simple wound measurements. Arch Dermatol 1998; 134: 1571-1574. 3.Bryant JL, Brooks TL, Schmidt B, Mostow EN. Reliability of wound measuring techniques in an outpatient wound center. Ostomy/Wound Management 2001;47(4):44-51.	Thank you for your comment.

86	Member, Provider	Laura Bolton, AAWC	2	Domain 1: Measuring and Staging Pressure Ulcers	4.Ennis WJ, Meneses P.Clinical evaluation: outcomes, benchmarking, introspection, and quality improvement. Ostomy Wound Manage. 1996;42(10A Suppl):40S-47S. 5.Bolton L, McNees P, van Rijswijk L et al. Wound healing outcomes using standardized care JWOCN 2004; 31(3):65-71. 6.Centers for Medicare and Medicaid Services "Guidance to Surveyors for Long Term Care Facilities" November 12, 2004 7.Sheehan P, Jones P, Caselli A, Giurini J, Veves A. Percent change in wound area of diabetic foot ulcers over a 4-week period is a robust predictor of complete healing in a 12-week prospective trial. Diabetes Care 2003; 26(6): 1879-1882. 8.Van Rijswijk L. and the Multi-Center Leg Ulcer Study Group. Full-thickness leg ulcers: Patient demographics and predictors of healing. J Family Practice 1993; 36(6): 625-632. 9.Phillips TJ, Machado F, Trout R, Porter J, Olin J, Falanga V. and The Venous Ulcer Study Group. Prognostic indicators of venous ulcers. J. Am Acad Dermatol. 2000;43:627-630. 10.Kantor J, Margolis DJ. A multicentre study of percentage change in venous leg ulcer area as a prognostic index of healing at 24 weeks. Br J Dermatol 2000; 142: 960-964.	
91	Public	Connie Blazek, Luther Hospital	2	Domain 1: Measuring and Staging Pressure Ulcers	Line 285 The current staging system as defined by NPUAP is what we utilize at our hospital. Though I agree with inaccuracy at times with the current staging system, the same issues will arise with determining partial vs. full thickness pressure ulcers.	e
95	Public	Robert Greene, UnitedHealthcare	2	Domain 1: Measuring and Staging Pressure Ulcers	Measurement of pressure ulcers: All three methods described are good, and certainly better than an inaccurate measure of the size of an ulcer. The most important issue is that the ulcer is measured using the same method each time. However, it would appear that the easiest one for evaluators to use would be the best choice. Method A (Box method) appears the most straightforward - choosing to measure the longest length of the ulcer, regardless of orientation on the body, and to measure the longest width perpendicular to this length. The method for re-classifying ulcers as partial thickness and full thickness instead of staging an ulcer is also a very useful reformulation. However, partial thickness also includes pressure areas where there is no breakdown of the skin - this would be better described by having its own category, perhaps named pressure area, skin intact.	Thank you for your comment.

98	Member, Health Plan	Catherine MacLean, WellPoint, Inc	2	Domain 1: Measuring and Staging Pressure Ulcers	Support the transition from staging and grading Delete the requirement to measure the depth of pressure ulcers Process to measure length is not as important as just choosing a standard process Recommend the flexibility at the facility to use other tools beyond the PUSH tool Clarify how to measure necrosis, undermining, tunneling, etc. Recommend adding surrounding skin and tissue characteristics as factors to look at Support public reporting of pressure ulcers but needs to be reported in a standard way Define "most severe" pressure ulcers Clarify if "number" relates to patients or pressure ulcers Recommend reporting on incidence not prevalence to direct quality improvement Recommend more specificity in the public reporting sub-domain Recommend reporting by unit within hospital or by patient population or transition site rather than facility as a whole	Thank you for your comment
102	Member, Provider	Richard Somsel, Tampa General Hospital	2	Domain 1: Measuring and Staging Pressure Ulcers	We strongly agree with using partial and full thickness to describe pressure ulcers as opposed to the current staging or grading system, as these stages are often recorded inaccurately and therefore have no real value.	Thank you for your comment.
103	Member, Provider	Richard Somsel, Tampa General Hospital	2	Domain 1: Measuring and Staging Pressure Ulcers	We feel length should be measured as the longest length, regardless of orientation and the width measured as the widest line perpendicular to the length. This give the best approximation of the actual size of the wound. Using head to toe orientation can make the wound appear smaller than it actually is when the wound is irregularly shaped.	Thank you for your comment.
107	Public	Teresa Mota, Quality Partners of Rhode Island	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.2: Since it is known that "resurfacing with epithelium most likely does not occur during a short acute care stay" will the post-acute care measure being reported on Nursing Home Compare be retired?	
125	Member, Purchaser	Barbara Rudolph, Ph.D., MSSW, The Leapfrog Group	2	Domain 1: Measuring and Staging Pressure Ulcers	Recommendations to change from staging to grading of pressure ulcers, seems to be a focus on semantics versus a focus on how to better identify and report on the presence of pressure ulcers acquired during a stay in a facility. We support the change, but again would like to have the report address how this will impact the quality of public reporting.	Thank you for your comment.
129	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	2	Domain 1: Measuring and Staging Pressure Ulcers	Mayo Clinic agrees with using closed rather than healed. Line 301.	Thank you for your comment.
131	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	2	Domain 1: Measuring and Staging Pressure Ulcers	Another suggestion was brought forward in regards to staging. For clinical purposes, the terms could be changed to "type" rather than "stage" and perhaps identified by letters rather than numbers, including DTI and unstageable in this schema.	Thank you for your comment.
132	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	2	Domain 1: Measuring and Staging Pressure Ulcers	Shear contributes to pressure ulcer development. Pressure ulcers that start with a shear injury should not be excluded. Line 387.	Thank you for your comment.

133	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	2	Domain 1: Measuring and Staging Pressure Ulcers	We believe the rate or percent, not just the number (See line # 418) of partial and full thickness ulcers would be more comparable and therefore better for public reporting. The denominator could be patient days or admissions or follow the incidence measure. We would suggest making the statement more clear regarding the most severe partial or full thickness injury; (e.g. largest open or the largest closed). Line 421	Thank you for your comment.
160	Member, Consumer	Carol Sakala, Childbirth Connection	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.1 (Staging of Pressure Ulcers): In addition, the definitions for full thickness injury require more clarity. For example, how would a pressure ulcer that has exposed muscle rather than exposed bone be defined? There is reference to exposed bone in the full thickness injury definition but not muscle.	Thank you for your comment.
161	Member, Consumer	Carol Sakala, Childbirth Connection	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.2 (Measuring Pressure Ulcers): In line 321, it is unclear what is meant by a tracing system for measuring pressure ulcers.	Technology used to measure pressure ulcers.
162	Member, Consumer	Carol Sakala, Childbirth Connection	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.3 (Tracking Outcomes and Severity of Pressure Ulcers): The report says partial thickness tissue injury pressure ulcer dimensions are difficult to obtain and often subjective which leads one to wonder why the switch to a new definitional system if it is not going to help with the measurement of the ulcers themselves. The title of this sub-domain is also confusing, since the options suggested for tracking and documenting pressure ulcers do not relate to outcomes. There is very little in this framework that relates to creating a framework for how to track patients outcomes in the treatment of pressure ulcers, and this sub-domain would obviously be the appropriate place to discuss this. We recommend added language in this section of the framework around the importance of tracking treatment and prevention outcomes, and options for how to do that.	Additional language incorporated into draft document.
163	Member, Consumer	Carol Sakala, Childbirth Connection	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.4 (Public Reporting on Pressure Ulcers): This is an important opportunity to cross-fertilize the framework with language from NQF-endorsed guidelines for consumer-focused public reporting. We recommend that this section be given more attention than the few short lines currently included, to reflect the important opportunity afforded by public reporting of pressure ulcer measures for consumers, their families, and non-paid caregivers. There should be reference made here as well to the current set of NQF-endorsed pressure ulcer measures, as examples of how measurement of pressure ulcers can be conveyed to consumers and purchasers. We urge NQF to develop a more thorough section on public reporting of pressure ulcer measures, including references to the endorsed guidelines, and discussion of	Thank you for your comment.
177	Member, Consumer	Debra Ness, National Partnership for Women and Families	2	Domain 1: Measuring and Staging Pressure Ulcers	Subdomain 1.1, continued: In addition, the definitions for full thickness injury require more clarity. For example, how would a pressure ulcer that has exposed muscle rather than exposed bone be defined? There is reference to exposed bone in the full thickness injury definition but not muscle.	Thank you for your comment.

186	Public	Madeleine Smith, AdvaMed	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.1 Staging of Pressure Ulcers: Line 267 We believe the current staging system is difficult for clinicians and changing the wording may be more confusing for staff, particularly staff that work across multiple care settings. If the staging system does change, we recommend it apply to all care settings and not be subject to additional future changes. We believe the difference between partial-thickness and full-thickness pressure ulcers will certainly be easier to distinguish and train staff on. Line 303 We agree with the words "open and closed" rather than "healed". It better describes the status of the wound as the maturation phase continues long after the wound is closed. Domain 1.2 - Measuring of pressure ulcers. Line 345 We agree with the wound measurement Best Area. We believe this will be easier to operationalize with staff, but it needs to be consistent across the continuum of care (acute, LTC, HHC, wound clinics, etc.). Domain 1.4 - Public Reporting. Line 413 Pressure ulcers should be reportable if acquired in a facility. We believe it is unfair to report pressure ulcers in a LTC facility that are acquired in another care setting present on admission, unless the pressure ulcer deteriorated in the LTC.	Thank you for your comment.
194	Member, Health Professi	Caitlin Connolly, American	2	Domain 1: Measuring and Staging Pressure Ulcers	The move from staging to grading is excellent and one that we endorse.	Thank you for your comment.
195	Member, Health Professionals	Caitlin Connolly, American Geriatrics Society	2	Domain 1: Measuring and Staging Pressure Ulcers	The commentary on the PUSH tool is thoughtful and important to note for improving practice.	Thank you for your comment.

199	Member, Health Plan	Rebecca Zimmermann, AHIP	2	Domain 1: Measuring and Staging Pressure Ulcers	AHIP and our member health plans have reviewed the Pressure Ulcer Framework and offer the following comments on the document's three domains. The three measurement methods for assessing ulcer size presented in the document are acceptable tools, however it is far more important that pressure ulcers are consistently assessed by the same tool throughout treatment than which tool is used. Pressure ulcers should be monitored and recorded through periodic photography and a consistent method of measurement should be noted. Additionally, while the PUSH tool is useful, it should not be the only measurement tool endorsed for assessment of ulcers as it cannot be used to categorize and measure larger ulcer wounds. AHIP recommends using the grading system offered as an option in the report to assess the size and severity of pressure ulcers rather than the staging measurement. In addition to the two categories of severity included in the report (partial and full thickness injuries), a third category should be included, pressure area, skin intact, to assess if and where there is breakdown of the skin. We also request additional specification in the report in the following areas: Unit of measurement rather than facility, report by hospital, patient population, or transition site. Public reporting section lacks specificity, including a definition for most severe ulcers.	Thank you for your comment.
208	Public	Joseph M. Del Duca, Meadowlands Hospital Medical Center	2	Domain 1: Measuring and Staging Pressure Ulcers	For DTI…..recommend we add a statement that the purple area is usually over a bony prominence and that there is no history of trauma	Thank you for your comment.
211	Public	Renee Visser, Pella Regional Health Center	2	Domain 1: Measuring and Staging Pressure Ulcers	I am new in the wound care department. Learning to orient my measurements is important so my co-workers all have the same technique. We find using the head to toe guide most convienient. Pressure ulcers are often somewhat cirucular in shape and the ratio changes from week to week. We include a measuring guide in the picture and mark the "headward" direction. There can be confusion on the foot however, because the heel is down and the toe is up when the patient is lying down. We choose to orient the picture with the plantar aspect fo the foot as down and the toes as vertical to the wound. This area could use better definition.	Thank you for your comment.

215	Public	Tammy Dietrich, St. Luke's Hospital	2	Domain 1: Measuring and Staging Pressure Ulcers	I would agree with the "box" technique using the longest dimension regardless of orientation and width the widest perpendicular measurement. I also agree that the depth is the deepest area perpendicular to the surface and not at a slant. This method more accurately decribes the size of the wound. One example would be a pt I had that had an upsidedown "V" wound on his abd that was quite large. If the length was measured as the longest length from head to toe, it would not have adequately described the size of the wound. This would be the same for any wound that was at a slant on the body, again the measurements would have made the wound seem smaller than it was. I would like to thank the National Quality Forum for all their hard work and guidance.	Thank you for your comment.
220	Member, Health Plan	Jed Weissberg, Kaiser Permanente	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.1 – Kaiser Permanente recommends reducing descriptors of pressure ulcers to two basic categories of open or closed. Two clarifications: A Stage II pressure ulcer is a partial thickness injury pressure ulcer, but a Stage I pressure ulcer is not (lines 286-287). Full thickness ulcers heal by granulation and then scar tissue formation, not by re-epithelialization. Partial thickness wounds heal by re-epithelization (lines 301-302).	Thank you for your comment.
221	Member, Health Plan	Jed Weissberg, Kaiser Permanente	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.2 – We agree with the need for clear, standard definitions for measuring pressure ulcers. In addition, we recommend addressing the “identification” of pressure ulcers, especially the identification of patients who are at risk for pressure ulcer development.	Thank you for your comment.
225	Public	Sarah Holden-Mount, American Medical Technologies	2	Domain 1: Measuring and Staging Pressure Ulcers	Dear NQF, Please accept these comments in response to your recent request for comments on the National Voluntary Consensus Standards for Developing a Framework for Measuring Quality for Prevention and Management of Pressure Ulcers. In regards to your suggested changes to the current staging system of pressure ulcers; "Stage I and II pressure ulcers to be graded as partial thickness injury pressure ulcers" "Stage III, IV pressure ulcers, deep tissue injury (DTI) and 'unstageable' pressure ulcers to be graded as full thickness injury pressure ulcers" We feel that this is an extraordinary way to document pressure ulcers. In many lectures provided to college students, along with educational activities provided to various employees in the long term care industry, we explain a similar description to them, and see a "light bulb" go off. In other words, they understand this and can easily apply. Therefore we completely support this change, and highly recommend your suggestions. Our only concern is categorizing a Stage I as a partial thickness injury as those present with intact skin. We understand tissue changes have occured, but a Stage I is not, by definition, a partial thickness injury.	Thank you for your comment.

228	Public	Clinical Nurse Specialist Team, University of California, San Francisco Medical Center	2	Domain 1: Measuring and Staging Pressure Ulcers	Thank you for the opportunity to provide feedback on this important consensus standard. 1. Definitions: We like the 2 category option for grading pressure ulcers. Pressure ulcers present as evolving or established. Is there a timeframe for identifying the grade of the injury as it may be a Stage 1(red, non-blanching) & 12 hrs later it is a suspected DTI (now purple, still non-blanching) or an initial assessment of a suspected DTI grade of Full Thickness Injury evolves over next 48 hrs to a Stage 2 (superficial skin loss, pink). These complexities have challenged our monitoring and reporting practices (California has mandatory reporting to DHS so it is important for us to be as accurate as possible). May consider adding "established or stable" and "evolving" as descriptors to address timeframe concern a. We agree with using "open" and "closed" as appropriate terminology as the variability in interpretation of "healed" and "healing" have complicated consistency in documentation of assessment of ulcers. b. Although, we realize the definition of DTI comes from NUPUAP, the literal definition of DTI,"….purple or maroon localized area of discolored INTACT skin or…" has created some confusion. This would not be an issue if we used the 2	Thank you for your comment.
232	Public	Julia Ringhofer, Scripps Mercy Hospital	2	Domain 1: Measuring and Staging Pressure Ulcers	I agree that the current staging system is performed so inconsistently that it needs to be simplified and that nurses assume that the ulcers follow the same progression. I believe nursing staff distinguish between intact skin and non intact and so would not easily classify current stage 1 and stage 2 as the same category. I like the idea of combining what is now 4 separate classifications into full thickness injury. Perhaps the staging system could be changed to have 3 " grades" Somehow the classification has to account for dynamics of the wound situation. as not all SDTI become full thickness open wounds. Another stumbling point currently is the granulating pressure ulcer which the staff typically classify as stage 3 because there is no way of knowing the original stage.The full thickness grade umbrella phrase would take care of that issue. Would it be useful to further classify the full thickness based on wound bed tissue: viable/nonviable/mixed??	Thank you for your comment.

235	Public	Lia van Rijswijk, La Salle University, School of Nursing and Health Sciences,Ostomy Wound Management	2	Domain 1: Measuring and Staging Pressure Ulcers	Partial Thickness and Full Thickness injury definitions A few weeks ago, the work of Dr.Gefen as it relates to deep tissue injury was published (PdF attached). In addition to supporting some of the NQF observations already included in the framework, the reported observations with respect to skin color and tissue firmness are worth noting since they are very important for clinical practice. Measuring Pressure Ulcers Perhaps it might help if the purpose of measuring pressure ulcers in clinical practice is included, e.g., the purpose is not to be 100% accurate vis-à-vis wound size but wounds are measured to track their progress. As such, simple geometric measurements of longest length and width and subsequent calculation of percent reduction in wound area have been found to predict healing in deep pressure ulcers (van Rijswijk & Polansky, reference attached) as well as a variety of other chronic wounds (see attached reference Dr.Sheehan).	Thank you for your comment.
238	Public	Robert Green, UnitedHealthcare	2	Domain 1: Measuring and Staging Pressure Ulcers	Measurement of pressure ulcers: All three methods described are good, and certainly better than an inaccurate measure of the size of an ulcer. The most important issue is that the ulcer is measured using the same method each time. However, it would appear that the easiest one for evaluators to use would be the best choice. Method A ("Box method") appears the most straightforward – choosing to measure the longest length of the ulcer, regardless of orientation on the body, and to measure the longest width perpendicular to this length. The method for re-classifying ulcers as "partial thickness" and "full thickness" instead of "staging" an ulcer is also a very useful reformulation. However, partial thickness also includes pressure areas where there is no breakdown of the skin – this would be better described by having its own category, perhaps named "pressure area, skin intact."	Thank you for your comment.

243	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.2 Measuring Pressure Ulcers NPUAP has studied the measurement of pressure ulcers, examining both validity and reliability. NPUAP recommends that pressure ulcers be measured from head to toe, using the longest dimension of the ulcer from head to toe as the length. Width is measured at a 90 degree perpendicular orientation at the ulcers widest area. This method was studied and reported on by Langemo and colleagues in 2008 as the most accurate and reliable measurement method. Important to pressure ulcer measurement is the ability of any instrument to have reliability over time. This important component of measurement is not addressed in the NQF documents at all. There is evidence that exudate is a marker of healing/nonhealing. This component of the PUSH scale was validated by Stotts (2001). The role of exudate as a marker of healing was also validated by the European Wound Management Association (2005). NPUAP is in support of photographs as one measure of pressure ulcer status and for comparison to determine if healing is occurring. Material on standardizing photographs has been published by NPUAP.	Thank you for your comment.
244	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.3 Tracking Outcomes and Severity of Pressure Ulcers This section of the document is a bit unclear and we will respond here to what we believe the NQF is proposing. NPUAP would be happy to dialogue with the NQF group on this issue if needed. If the data on pressure ulcers changed as NQF is recommending, how would outcome tracking work? If a patient had a “partial thickness” ulcer that became a “full thickness ulcer”, that could be an ulcer going from a stage I or II to a stage III or IV or deep tissue injury or unstageable. There is a huge difference between a stage I becoming a III than becoming an unstageable pressure ulcer! These paragraphs demonstrate a lack of understanding of the clinical tools that have been developed and validated to “monitor progress… or a lack of progress toward healing”. These include the PUSH tool by NPUAP and the BWAT by Bates-Jensen. Sonata is also mentioned…. Perhaps the authors are referring to the work of Hiromi Sanada. A comprehensive review of the literature completed for the EPUAP-NPUAP International guidelines revealed much more reliability and validity testing than represented in this document. Both the PUSH Tool and the BWAT have been used in research studies to measure healing and found to be reliable and valid NPUAP supports the outcome measure of healed stage II pressure ulcers at 30 and 60 days. We believe that it is biologically possible to heal stage II ulcers in that time with proper care. Therefore, we would not see this measure of “healed” versus “not healed” as only an internal measure of quality.	Thank you for your comment.

245	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	2	Domain 1: Measuring and Staging Pressure Ulcers	Domain 1.4 Public Reporting of Pressure Ulcers NPUAP believes that most pressure ulcers are preventable and supports public reporting of pressure ulcer data. The reporting of all pressure ulcer data would be burdensome and prone to misunderstandings by the public. It is NPUAP's opinion that Stage III, IV and unstageable ulcers be publicly reported. When the diagnosis of deep tissue injury is more reliable, NPUAP will make a determination if DTI should also be reported. NPUAP also supports public reporting of risk stratification, so that better comprehension of the underlying risk factors for pressure ulcer development can be understood.	Thank you for your comment.
16	Public	Denise Elber, Parma Hospital	3	Domain 2: Analytics	Agree with lines 496-499. In addition unfortuneately no documentation and wound present. Agree with need for continuity across the continuum of care to have comparable data.	Thank you for your comment.
27	Public	Colleen Karvonen, UWMC	3	Domain 2: Analytics	(504-517) Exclusion criteria regardless of specificity is applied subjectively, to some extent. Specific exclusion criteria needs to be publically reported along with the number of patients and/or percentage of patients excluded in order to give an accurate portrayal of a facilities incidence or prevalence data. A specific facilities data may look better or worse based on the degree to which they include every patient in their numbers. Patients develop ulcers when they are too unstable to turn/move or refuse to turn/move and thus prevention methods are not or cannot be implemented. This does not mean these patients should be excluded from reporting, rather these ulcers may not be preventable for specific reasons.	Thank you for your comment.
34	Public	Kathleen Francis, Visiting Nurse Service of NY	3	Domain 2: Analytics	I think it would be good to track outcomes. We are already sort of doing this in Homecare (OASIS). We are collecting the information. This may not be the case across the continuum for a variety of reasons.	Thank you for your comment.
46	Member, Provider	Donald Casey, Atlantic Health	3	Domain 2: Analytics	Domain 2.2.: Look into systems that support data of only those pts whom were assessed in real-time but documented in EMR, then there would be true numbers and accuracy.	Thank you for your comment.
69	Public	Julia Powell, National HealthCare Corp	3	Domain 2: Analytics	When you exclude a patient in one site because of shortness of the stay, you lose some pieces of information across the continuum of that patient's care. I'm not sure how to handle but believe patienn in multiple sites of care need some "special" consideration.	Thank you for your comment.
70	Public	Julia Powell, National HealthCare Corp	3	Domain 2: Analytics	Shouldn't goals of care be linked some how to incidence/prevalence?	Thank you for your comment.

75	Public	Deborah Baehser, Cape Regional Medical Center	3	Domain 2: Analytics	The criteria for public reporting, inclusion and exclusion criteria could create unwanted variability between reporting institutions and confuse the public. Institutions are already using multiple methods for reporting incidence and prevalence depending upon the requirements of the benchmarking entity. Concerned about limiting access to the electronic medical record for data collection.	Thank you for your comment.
81	Member, Health Professionals	Rita Munley Gallagher, PhD, RN, American Nurses Association	3	Domain 2: Analytics	Domain 2.3 The American Nurses Association (ANA) recommends Principle 1 Page 13: Line 504 be revised to read: Be inclusive as possible and the remaining verbiage (Lines 504-509) relocated to Domain 3.3 as it lacks standardization which has the potential to lead to loss of validity of the measure. The focus in Domain 2.3 is outcome measures. This exclusion refers to processes and, hence, should be relocated. In addition, ANA recommends the deletion of Lines 513-514 given the lack of a standardized definition for short stay. Short stay in hospitals may refer to same day surgery patients or patients who are under observation for less than 24 hours but this definition is not fully explicated within the document. The example provided (48 hour cardiovascular hospital stay) is confusing in that it: -Refers to a hospital which would naturally fall within the category referenced in Line 510 ~ exceptionally low risk population -Incorrectly infers that pressure ulcers will not develop in less than 48 hours of hospitalization -Is inconsistent with risk stratification by hospital size and unit type	These changes have been made in the revised framework document.
87	Member, Provider	Donald Casey, Atlantic Health	3	Domain 2: Analytics	Domain 2.1-2.4 We believe that measuring incidence gives you a more accurate measurement of facility-acquired pressure ulcers across a period of time. However, it is work intensive, staff intensive and may not be feasible at most facilities. Therefore we recommend the use of point prevalence on a monthly or quarterly basis using the NDNQI measurement systems. We do not recommend the use of retrospective extraction of pressure ulcer data from the medical record because of discrepancies that may occur due to physician documentation concerning pressure ulcer staging treatment. As members of the North Central New Jersey for the partnership for the prevention of pressure ulcers, we believe it is critical to standardized process for collecting and reporting facility-acquired pressure ulcer data for like facilities and across the continuum when possible; however, in some cases as evidenced by our work in the partnership, other national reporting programs, e.g., OASIS in home care vs. NDNQI in hospitals, require varying methodologies. Research needs to be conducted to test the feasibility and impact of shared reporting between facilities. Thru the use of OASIS data we can identify the presence of a pressure ulcer only when OASIS data is collected (Admission, Resumption- following hospital stay, Recertification (60 day intervals), and at Discharge). Data collection is problematic.	Thank you for your comment.

88	Member, Provider	Donald Casey, Atlantic Health	3	Domain 2: Analytics	Domain 2.2.: DM/AR/SD: Look into systems that support data of only those pts whom were assessed in real-time but documented in EMR, then there would be true numbers and accuracy.	Thank you for your comment.
92	Public	Connie Blazek, Luther Hospital	3	Domain 2: Analytics	Section 437 Our hospital currently does monthly prevalence studies including patients on all inpatient units excluding Behavioral Health and Women's Health with quarterly reporting of data to NDNQI.	Thank you for your comment.
96	Public	Robert Greene, UnitedHealthcare	3	Domain 2: Analytics	Analytics: The request is to state whether Incidence or Prevalence of ulcers at a facility are preferred as a measure. We prefer Incidence for two reasons: 1)Incidence more accurately reflects whether an ulcer occurred while in the facility (no ulcer on arrival, yes ulcer on re-assessment). This more accurately reflects the quality of care provided than does prevalence (the patient could have arrived with an ulcer at admission) 2)Incidence could possibly be assessed from administrative data, which is easier and less costly to utilize that survey or chart review instruments. The Inclusion and Exclusion criteria for assessment are rational, but need more detail in order to be useful in the final measure (for example, specifically state the number of hospital days for a short term stay where an assessment of ulcer incidence does not need to be done). Risk adjustment should include facility size, as well as individual patient factors.	Thank you for your comment.
99	Member, Health Plan	Catherine MacLean, WellPoint, Inc	3	Domain 2: Analytics	Well thought out, qualifiers are good. Recommend adjustments for similar patient type (palliative care) or by care unit to better identify opportunities for improvement	Thank you for your comment.
108	Public	Teresa Mota, Quality Partners of Rhode Island	3	Domain 2: Analytics	Reading through Domain 2.3 I noticed there is no mention of terminal ulcers (a.k.a. Kennedy), although in Domain 3.5 there is mention of palliation in relation to the plan of care. Will there be exclusions in the measure related to terminal ulcers?	Thank you for your comment.

114	Member, Purchaser	Gaye Fortner, HealthCare 21 Business Coalition	3	Domain 2: Analytics	Line 430- : I suggest adding consumers, families, and unpaid caregivers. Analytical measurement of pressure ulcers must reflect the patient/consumer as well as the roles of their informal caregivers in prevention and treatment. Domain 2.1- I recommend that more attention be given to the incidence of pressure ulcers. Domain 2.2- Line 492, regarding the capture of data on where pressure ulcers were acquired, must include home-based care in addition to hospitals and facilities. Domain 2.3- Line 507, regarding the exclusion of patients who are malnourished despite maximal provider support, unless there is a way to accurately quantify that type of support in a way that goes beyond checking off a box on a form, this population should not be excluded. Domain 2.4- We question whether or not risk adjustment is appropriate for this condition. For example, the California Health Care Foundation's Nursing Home Ratings website (www.calnhs.org) stratifies pressure ulcers according to high risk and short stay. The first issue is whether pressure ulcers are preventable; if so, then it begs the question of whether patients should assume they would receive care appropriate to preventing pressure ulcers, regardless of facility. At this point, there needs to be more input on this question and more discussion and evidence for the need for risk adjustment before this sub- domain is finalized in the framework.	Thank you for your comment.
120	Member, Purchaser	Shari Ling, CMS/OCSQ/QMHAG	3	Domain 2: Analytics	Incidence measures require a specified time interval. This should be specified and applied uniformly between facilities and environments. If the time interval is specified the incidence would be more easily comparable between facilities, environments, etc. What is the ideal observation time interval?	Thank you for your comment.
126	Member, Purchaser	Barbara Rudolph, Ph.D., MSSW, The Leapfrog Group	3	Domain 2: Analytics	We agree that it is easier to report on prevalence than incidence but it begs the question of where care was less than adequate. We support the measurement of incidence for public reporting; and we support the use of stratification rather than risk adjustment for public reporting. We believe that consumers are better able to understand and use information based on stratified populations--and frankly it is likely that providers also can better use stratification to identify where to focus on improvement in care delivery.	Thank you for your comment.
127	Member, Purchaser	Barbara Rudolph, Ph.D., MSSW, The Leapfrog Group	3	Domain 2: Analytics	The Leapfrog Group supports efforts by other providers, such as STS, to move away from case exclusions. We do accept that patients with short stays (2 days or less) should be excluded from that specific institutions rate of acquired pressure ulcers. Any other exclusions, might be better addressed through stratification, or a stated caveat that consumers should not expect 100% prevention of pressure ulcers.	Thank you for your comment.

128	Member, Purchaser	Barbara Rudolph, Ph.D., MSSW, The Leapfrog Group	3	Domain 2: Analytics	The report comments on the lack of accuracy in chart abstracted data; yet, given the excess payments for additional LOS and treatment for pressure ulcers, we should be able to rely on the use of administrative data with present on admission indicators for lengths of stay greater than 2 days. Until a better method of data collection is identified, we should rely on the source that documents the excess.	Thank you for your comment.
135	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	3	Domain 2: Analytics	The incidence and prevalence measures section is a bit confusing. We would support the use of the incidence definition provided for measuring setting-acquired pressure ulcers and the prevalence definition provided for measuring overall pressure ulcers in the population being studied.	Thank you for your comment.
136	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	3	Domain 2: Analytics	In the inpatient setting, the prevalence of pressure ulcers can be queried successfully from the electronic medical record when combined with additional record review by an RN to verify presence on admission. We have done this and compared it with direct observation during the same timeframe and found the results of the two methods to be consistent. Additionally, querying the electronic medical record allows for a more accurate reflection of the full 24 hours, rather than the 1 to 3 hours a team might observe on a patient care unit using the direct observation method.	Thank you for your comment.
137	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	3	Domain 2: Analytics	We appreciate the attempt at inclusion and exclusion principles; however, we have some comments: We agree that subjects on comfort/palliative care at end of life should be excluded. Applying exclusion criteria seems like a good idea to make the data more accurate and comparable across sites by excluding those patients where individual preferences or goals of care prevent implementation of evidence-based pressure ulcer prevention strategies. The challenge will be to define and implement this in a consistent manner. The exclusion starting on line 504 seems reasonable, but that on line 511 does not as it includes unstable and off the unit patients. We are wondering if line 511 was meant to track the individuals where you cannot perform the direct observation for measurement. If the latter is the case, this line should be re-worded to clearly state this.We believe more discussion is needed around excluding short stay hospital patients. A pressure ulcer can develop within 48 hours in some high risk patient populations.We agree that exclusion criteria need to be specifically and clearly identified for public reporting.	Thank you for your comment.
138	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	3	Domain 2: Analytics	We agree with the development of a risk-adjustment. This is very important. We have found that length of stay, multi-organ system failure and dialysis are the 3 highest risk factors. Risk adjustment is very important and should include a rationale relating the variable to the outcome as described.	Thank you for your comment.

152	Member, Purchaser	Shari Ling, CMS	3	Domain 2: Analytics	One important criticism pertains to the issue of risk adjustment. Although risk adjustment allows us to comprehend the prevalence and incidence of pressure ulcers given specific pre-defined conditions (e.g. co-morbidity, illness severity), it also limits our ability to understand the extent to which they affect or are affected by pressure ulcers. Moreover, if used as a performance bench-mark, risk-adjusted estimates may impede the field's progress towards achieving the best management practices in the sickest or most medically complicated patients despite the worst conditions.	Changes have been made to the draft framework document to address risk-adjustment.
164	Member, Consumer	Carol Sakala, Childbirth Connection	3	Domain 2: Analytics	Line 430: In addition to performing analyses at the provider, system, community, and geographical area levels, we suggest adding consumers, families, and unpaid caregivers. Analytical measurement of pressure ulcers must reflect the patient/consumer as well as the roles of their informal caregivers in prevention and treatment.	Thank you for your comment.
165	Member, Consumer	Carol Sakala, Childbirth Connection	3	Domain 2: Analytics	Domain 2.1 (Incidence and Prevalence): we recommend that more attention be given to the incidence of pressure ulcers. Incidence provides a greater level of information for consumers and family caregivers than prevalence. Incidence is also a more useful measure than prevalence for internal quality improvement and accountability.	Thank you for your comment.
166	Member, Consumer	Carol Sakala, Childbirth Connection	3	Domain 2: Analytics	Domain 2.2 (Measuring Incidence and Prevalence): Line 492, regarding the capture of data on where pressure ulcers were acquired, must include home-based care in addition to hospitals and facilities.	Thank you for your comment.
167	Member, Consumer	Carol Sakala, Childbirth Connection	3	Domain 2: Analytics	Domain 2.3 (Inclusion and Exclusion Principles): Line 507, regarding the exclusion of patients who are malnourished despite maximal provider support, two questions arise. First, is there any evidence that the number of patients who fit into this category is large enough to warrant an exclusion? And if so, how would maximal provider support be accurately measured? Unless there is a way to accurately quantify that type of support in a way that goes beyond checking off a box on a form, this population should not be excluded.	Thank you for your comment.
168	Member, Consumer	Carol Sakala, Childbirth Connection	3	Domain 2: Analytics	Domain 2.4 (Risk-adjustment): We question whether or not risk adjustment is appropriate for this condition. For example, the California Health Care Foundation's Nursing Home Ratings website (www.calnhs.org) stratifies pressure ulcers according to high risk and short stay. The first issue is whether pressure ulcers are preventable; if so, then it begs the question of whether patients should assume they would receive care appropriate to preventing pressure ulcers, regardless of facility. At this point, there needs to be more input on this question and more discussion and evidence for the need for risk adjustment before this sub-domain is finalized in the framework.	Additional language incorporated into draft document.

187	Public	Madeleine Smith, AdvaMed	3	Domain 2: Analytics	Domain 2.1 Incidence and Prevalence. Line 435 We are in favor of measuring and reporting pressure ulcer incidence. We believe this will facilitate the tracking of implementation of prevention measures by facilities, and not just the number of pressure ulcers in a facility. It may be more difficult to monitor, but it is better data to work with for improvement of prevention measures and well as evidence-based management. Domain 2.2 - Measuring Incidence and Prevalence. Line 475 We agree with the proposed definitions. However, we recommend that all wound care organizations and professional societies agree on these definitions (WOCN, NPUAP, AMDA, NDNQI, NQF, etc.)	Thank you for your comment.
200	Member, Health Plan	Rebecca Zimmermann, AHIP	3	Domain 2: Analytics	AHIP recommends reporting incidence rather than prevalence rates as incidence can more readily be used to direct quality improvement efforts. Incidence more accurately assesses whether an ulcer occurred while in the facility. Incidence could also be assessed from administrative data, which is easier and less costly to utilize that survey or chart review instruments. We also recommend that measures include risk adjustment by care type, hospital size, and patient factors in order to appropriately identify areas for improvement. Additional specificity on what would constitute a short-term stay should also be included.	Thank you for your comment.
222	Member, Health Plan	Jed Weissberg, Kaiser Permanente	3	Domain 2: Analytics	Domain 2.2 – Kaiser Permanente recommends moving to real-time reporting rather than reporting data obtained from retrospective chart review and proposes the NQF provision of clear definitions and methodology that are also reproducible across institutions.	Thank you for your comment.

231	Public	Clinical Nurse Specialist Team, University of California, San Francisco Medical Center	3	Domain 2: Analytics	Tracking: Lines 387-392: we like the list of what are not included as pressure ulcers, yet the "shearing" and "skin tears" may be misinterpreted. Is there a way to enhance description of these skin alterations by giving examples with non pressure locations, etc. We do not see mention of tracking and reporting "device related pressure injury" . E.g. DTI from ear clip Sp02 (pulse oximetry) probe, nares ulceration related to NG or feeding tube pressure against the site. Some institutions track and include them in their reporting as generic pressure ulcers. Would this be a subcategory or non-reportable (not inferring that it should not be monitored and addressed at hospitals/sites). Reporting To address concept in lines 504 and 505 ("…where preventive measures are contraindicated for specific individuals, those may be excluded"): Recommend "Avoidable" or "Unavoidable" as part of reporting framework with specified criteria (would need to be determined) in reporting. Examples regarding goals of care that include end-of-life, self –determined plans of pts, clinically unstable (severe alteration in hemodynamic or respiratory condition precluded transfer to appropriate surface or ability to reposition), goal to immobilize pt for a period of time to avoid complications of therapy/procedures (post-operative microvascular surgical procedures, open chest or abdominal situations, prevent occlusion of blood flow through cannulae of ECLS/ECMO/VAD, etc)	Thank you for your comment.
233	Public	Julia Ringhofer, Scripps Mercy Hospital	3	Domain 2: Analytics	Since CMS will no longer cover the costs of a HAPU we are further galvanized to be creative in finding ways to provide the care to those difficult pts. even if a % of this type pt will go on to acquire a HAPU. It seems it would be hard to standardize which ulcers are considered inevitable and therefore excluded?	Thank you for your comment.
239	Public	Robert Green, UnitedHealthcare	3	Domain 2: Analytics	Analytics: The request is to state whether Incidence or Prevalence of ulcers at a facility are preferred as a measure. We prefer Incidence for two reasons: 1) Incidence more accurately reflects whether an ulcer occurred while in the facility (no ulcer on arrival, yes ulcer on re-assessment). This more accurately reflects the quality of care provided than does prevalence (the patient could have arrived with an ulcer at admission) 2) Incidence could possibly be assessed from administrative data, which is easier and less costly to utilize that survey or chart review instruments. The Inclusion and Exclusion criteria for assessment are rational, but need more detail in order to be useful in the final measure (for example, specifically state the number of hospital days for a "short term stay" where an assessment of ulcer incidence does not need to be done). Risk adjustment should include facility size, as well as individual patient factors.	Thank you for your comment.

246	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	3	Domain 2: Analytics	Domain 2.1 Incidence and Prevalence NPUAP supports the collection of both prevalence and incidence at local and national levels. Prevalence data can provide a view of the "burden of pressure ulcers" at a national or local level. We do not support the use of prevalence as a measure of quality because facilities which accept and treat patients with pressure ulcers could be seen as providing substandard care based on "numbers alone". NPUAP supports the concept of agency or facility acquired pressure ulcer incidence. Due to the potential for error when the medical record is used as the baseline, we further recommend that the facilities audit these results with "spot checks" to validate the accuracy of the baseline report. The established definitions for incidence and prevalence provided by the NQF document do little to help clarify the terms. For example, "the event in question" in this document is a pressure ulcer. A recent consensus document (2009) on Pressure Ulcer Prevention: Prevalence and Incidence in Context provides clear definitions and examples of how to compute the numbers. Common errors in determining prevalence and incidence are also discussed. NPUAP has long asked for consistency in measurement so that meaningful comparisons can be made. If the NQF is going to have an opinion on how to measure prevalence and incidence, we hope it can clarify and amplify the work of others.	Thank you for your comment.
247	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	3	Domain 2: Analytics	Domain 2.2 Measuring Prevalence and Incidence NPUAP supports the concept of beginning the assessment of pressure ulcers upon admission to any facility. This conclusion is premised on the belief that all nurses in all settings can identify and diagnose pressure ulcers and distinguish them from other skin lesions. This is also premised on the belief that at a local system level, root cause analysis and quality improvement projects are currently performed based on the stage of the pressure ulcers. NPUAP does not see a clear method of examining system issues if "partial" and "full thickness" were the only descriptors. Many facilities today are looking into the problem of deep tissue injury and examining the operating room table mattresses, the Emergency Department carts and lengths of stay in these two settings. We believe that each system should follow their policies on the time frame acceptable for admission assessment. Mandating a specific period of time for admission assessment is impractical; there will be too many legitimate exceptions to it.	Thank you for your comment.

248	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	3	Domain 2: Analytics	Domain 2.3 Inclusion and Exclusion Principles NPUAP agrees with the exclusion of low risk patients, such as obstetrics and short stay patients. These criteria appear to be clear and logical. However, the recommended exclusion of very high risk patients, such as immobile patients who refuse support surfaces or the malnourished patient who will not be tube-fed creates a huge loop hole in data monitoring. These are the very patients that the hospital will not receive payment for the pressure ulcer in the new payment system. These are the very patients that we need to understand how to help. The NQF should recognize that these patients also need quality care and strive to improve outcomes in these patients also.	Thank you for your comment.
249	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	3	Domain 2: Analytics	Domain 2.4 Development of Risk Adjustment Models NPUAP supports the development of risk adjustment models and believes that all patients should be included in the model, especially the high risk patients discussed in Domain 2.3.	Thank you for your comment.
18	Public	Denise Elber, Parma Hospital	4	Domain 3: Prevention and Healing	Expert opinion comment on avoiding negative pressure on weight-bearing areas. Would expect area to be off-loaded or off-weighted during this therapy and not necessarily avoided. Need to take the wet-to-dry wet-to-moist to the medical schools and medical conferences. Although a recent article re biofilms lent credance to frequent dressing changes may be more theraputic. Wound Management line 638 should read pressure redistribution and not relief as follows	Thank you for your comment.
20	Public	Ruth Rauscher, Retired	4	Domain 3: Prevention and Healing	Lines 591-596, Item 4. Treatment Plan. I recommend strongly that information on nutrition and hydration portions of the plan of care be transmitted acress patient care settings. This should be stated in terms of the entire Nutrition Care Process as the nutritional assessment, leading to specifics on the nutrition and hydration aspects of the plan of care. This allows the patient to receive appropriate care (comparable, progressive) in these areas. This data can also be collected and analyzed to determine most effective treatments in the areas of nutrition and	Thank you for your comment.
28	Public	Colleen Karvonen, UWMC	4	Domain 3: Prevention and Healing	(536-547)An 8 hour assessment window is too tight and not practical in many cases. If a patient is hemodynamically unstable, it may be unrealistic and unsafe to do a complete head to toe skin assessment. I think facilities need to make a good faith effort to complete the assessment within 12-24 hours, and if not done, address in writing specifically why the assessment was not completed. If the patient transfers from one department to another (i.e. ER to ICU)prior to the skin assessment being completed, the reason needs to be addressed in writing at that time.	Thank you for your comment.
71	Public	Julia Powell, National HealthCare Corp	4	Domain 3: Prevention and Healing	not sure what a head to toe PU risk assessment is?	Most commonly used tools to assess pressure ulcer risk include the Braden scale© and PUSH tool©
72	Public	Julia Powell, National HealthCare Corp	4	Domain 3: Prevention and Healing	Assessment within 8 hours of arrival seems reasonable except in locations where the length of time is less than 8 hours. Should presume risk for elderly frail pateints until assessment proves it unnecesary.	Thank you for your comment.

76	Public	Deborah Baehser, Cape Regional Medical Center	4	Domain 3: Prevention and Healing	The eight-hour maximum timeframe for the head-to-toe skin and pressure-risk assessment, including Emergency Department time seems too limited. While the need for standardization across the continuum is necessary, including acute care in this window may be more problematic.	Thank you for your comment.
78	Public	Sharon McCauley, American Dietetic Association	4	Domain 3: Prevention and Healing	The American Dietetic Association supports the Prevention Strategies for nutrition and hydration through assessment parameters as described in the report. The nutrition care plan should be included in collaboration with the patient and/or caregivers.	Thank you for your comment.
82		Rita Munley Gallagher, PhD, RN, American Nurses Association	4	Domain 3: Prevention and Healing	Domain 3.1 While an 8 hour assessment limit for skin and pressure ulcer risk assessment is ideal, it may not always be possible in: 1) hospitals due to intervening variables such as surgery etc and/or 2) home health care due to conflicts in home health staff/patient schedules. Therefore, the American Nurses Association (ANA) recommends: A head-to-toe skin assessment and the pressure ulcer risk assessment should ideally be done within 8 hours of admission to the setting (including arrival in the emergency department). Domain 3.3 The American Nurses Association (ANA) recommends the prevention strategy: consideration of whether prevention processes were performed should take into account patient refusal of prevention or situations where the process of care is contraindicated/not appropriate be included here. Domain 3.4 The American Nurses Association (ANA) notes that line 598 should be revised to read last score or clinical factor(s) that placed the patient at-risk.	Thank you for your comment.
89	Member, Provider	Donald Casey, Atlantic Health	4	Domain 3: Prevention and Healing	Domain 3.1: ED should be accountable for the assessment or prevention process of pressure ulcers as they are a vital part of the hospital and patient process and should be aware and able to document on the patient that is being cared for.	Thank you for your comment.
93	Public	Connie Blazek, Luther Hospital	4	Domain 3: Prevention and Healing	Section 655 (domain 3.7) Yes-will this info be shared with all levels of pt. care providers?	Yes, this information is meant to be shared with all levels of patient care providers - i.e. nurses, physicians, therapists, etc.
97	Public	Robert Greene, UnitedHealthcare	4	Domain 3: Prevention and Healing	Prevention and Healing: NQF specifically is seeking comment on whether the requirement for a head to toe assessment of the skin of a patient in 8 hours from admission is a good time window to use to assess prevention activities. We concur that the head-to-toe skin assessment performance within 8 hours of admission is an important prevention strategy and is reasonable for a facility. The rest of the recommendations in this section on prevention and healing are reasonable.	Thank you for your comment.

100	Member, Health Plan	Catherine MacLean, WellPoint, Inc	4	Domain 3: Prevention and Healing	Footnote is incorrect identifying the PUSH tool as a skin assessment tool Recommend head to toe assessment within 8 hours be directed at high risk patients/units. Review present on admission for all high risk patients Recommend setting different time standards and repetitive assessments based on risk level of patients Delete depth measurement from all areas	Thank you for your comment.
104	Member, Provider	Richard Somsel, Tampa General Hospital	4	Domain 3: Prevention and Healing	The 8 hour time frame is unrealistic for very ill patients or severely injured trauma patients coming into the Emergency Room. Patients may spend a few hours in the Emergency Room, then spend several hours in surgery, and the combined total may then be outside the 8 hour time frame. After leaving surgery, patients may still be too unstable 'to turn' to complete a full assessment. The requirement should be a full assessment is to be completed when it is reasonably safe for the patient to be assessed. This can usually be completed within 24 hours.	Thank you for your comment.
105	Member, Provider	Richard Somsel, Tampa General Hospital	4	Domain 3: Prevention and Healing	Negative-pressure wound therapy does not necessarily consist of an open-cell foam dressing covered with an adhesive drape. There are other types of negative pressure wound therapies the do not use open-cell foam.	Thank you for your comment.
109	Public	Teresa Mota, Quality Partners of Rhode Island	4	Domain 3: Prevention and Healing	Domain 3.1: Pressure ulcer risk, I believe, could be accomplished within one calendar day of admission. This would allow for monitoring of patient mobility, activities, ADL status, etc. Domain 3.4: In support of effective care transitions, consider EMS personnel and their need for knowledge of how to transport the frail elderly and especially those at risk of developing or those who already have pressure ulcers. Domain 3.6: #15 - would insert the words "and goals" after "functional independence" to main consistent with items in Domain 3.5. Domain 3.6: Final bullet - insert examples.	Thank you for your comment.
115		Gaye Fortner, HealthCare 21 Business Coalition	4	Domain 3: Prevention and Healing	Domain 3.1- I suggest that language be added in this domain to clarify that a thorough assessment is necessary and should be routinely performed on patients who are at higher risk of pressure ulcers, but that it is not something that would fall under the realm of a performance measure and be suitable for a measurement framework. Domain 3.3- I suggest adding a bullet on how critical it is to prevention for providers to collaborate with family and unpaid caregivers. Domain 3.4- I suggest adding a sixth bullet on the measurement of whether outcomes are assessed at regular intervals to ensure that patients, along with their providers, families, and unpaid caregivers are following their treatment regiments. Domain 3.5- Add family and unpaid caregivers to the list of groups with which a realistic care plan must be developed.	Thank you for your comment.

121	Member, Purchaser	Shari Ling, CMS/OCSQ/QMHAG	4	Domain 3: Prevention and Healing	Implementation of an endorsed risk assessment tool should be recommended. Evidence supports the Braden Scale given its test characteristics and should be implemented in total (6-23) and subscales (sensory perception [1-4], moisture[1-4], activity[1-4], mobility[1-4], nutrition[1-4], friction and shear [1-3]) with higher scores representing less risk. However, evidence was based on stages.	Thank you for your comment.
141	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	4	Domain 3: Prevention and Healing	We fully support that pressure ulcer pathophysiology, evaluation and treatment should be included in medical school curricula and all primary professional training. In addition, remedial education is needed for all professional staff and patients. This will be a significant undertaking.	Thank you for your comment.
142	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	4	Domain 3: Prevention and Healing	Domain 3.3 Prevention Strategies: We support that the prevention strategies are general and allow for flexibility within a framework that considers goals of care and individual patient circumstances. The primary prevention strategy is off-loading at risk areas (turning, etc). Turning should be the first bullet with pressure distributing surfaces to be used when off loading is inadequate or impossible. Prevention strategies should also include prevention of shear during transfers and mobilization, as well as padding of external devices (collars, orthoses, etc.). To be inclusive of patients in the community, we would suggest the last bullet be changed to: Daily or repetitive skin inspection for/by at-risk patients. In regard to frequency of turning, we would appreciate formal recommendations related to the at-risk patient and if there should be any frequency difference with the advances in technology related to pressure reduction and redistribution.	Thank you for your comment.
143	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	4	Domain 3: Prevention and Healing	Domain 3.4 Transitions of Care: We support that the plan should communicate specific items and follow the patient across settings. Line 584: consider including presence of osteomyelitis/infection, if known. Why only track largest and only full thickness injury (line 590)? For continuity across the care continuum (vs. reporting), we believe all ulcers need to be tracked.	Thank you for your comment.
144	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	4	Domain 3: Prevention and Healing	Domain 3.6 Wound Management: Bacterial burden has been historically and repeatedly shown to effect wound healing. This is not infection, but rather colonization and is treated locally/topically. This should be number one instead of infection, which is clearly much rarer. In the presence of an actual ulcer, pressure distribution is completely inadequate. The involved area must be completely off-loaded. #4 should be changed to reflect this. Consider including recommendations on cleansing wounds. Defining a minimum for "regularly scheduled" wound evaluation for a pressure ulcer would be important.(#10) Please consider including resources for defining "evidence-based timeframe" for effective wound progress.	Thank you for your comment.

145	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	4	Domain 3: Prevention and Healing	Domain 3.7 Strategies to Avoid: Why should we avoid wet to moist dressings in long term management? A properly performed wet to moist dressing on a low-exudative wound can be an option for both long term and short term treatment.	Thank you for your comment.
149	Public	Cindy Marois, Covidien	4	Domain 3: Prevention and Healing	Under Prevention strategies you may want to address the need to avoid friction and shear since these are 2 ways a pressure ulcer can be acquired while in an acute care setting. This should also be addressed under the Wound Management section.	Thank you for your comment.
150	Public	Cindy Marois, Covidien	4	Domain 3: Prevention and Healing	Would it be helpful to put together tools to support patients and caregivers once the patient leaves the acute care setting. If not all pressure ulcers will be closed or healed when the patient leaves, this could provide the caregivers with information and tools to continue treatment and ultimately close/heal the wound.	Thank you for your comment.
179		Carol Sakala, Childbirth Connection	4	Domain 3: Prevention and Healing	Domain 3.1 (Assessment): While we support the idea of a head-to-toe screening of patients who are at high-risk for pressure ulcers upon admission, this recommendation would not translate to a performance measure that indicates superior quality of care. In other words, a head-to-toe assessment shortly upon arrival should be a basic competency, rather than a measure of high performance. We suggest that language be added in this domain to clarify that a thorough assessment is necessary and should be routinely performed on patients who are at higher risk of pressure ulcers, but that it is not something that would fall under the realm of a performance measure and be suitable for a measurement framework.	Thank you for your comment.
180	Member, Consumer	Carol Sakala, Childbirth Connection	4	Domain 3: Prevention and Healing	Domain 3.3 (Prevention Strategies): We strongly suggest adding a bullet that provider collaboration with family and unpaid caregivers is critical to prevention.	Thank you for your comment.
182	Member, Consumer	Carol Sakala, Childbirth Connection	4	Domain 3: Prevention and Healing	Domain 3.5 (Development of Plan of Care): We strongly recommend adding family and unpaid caregivers to the list of groups with which a realistic care plan must be developed.	Thank you for your comment.

188	Public	Madeleine Smith, AdvaMed	4	Domain 3: Prevention and Healing	Domain 3.1 - Assessment Line 541 We believe putting a time frame for conducting a skin and pressure ulcer risk assessment. However, 8 hours post admission seems too long as pressure ulcers can develop within 2 hours of unrelieved pressure. CMS states that documentation of pressure ulcers POA for inpatient stays occur "at time of admission". Our preference is for strict adherence to that standard, but we realize that is not always possible or realistic. We would recommend "within 2 hours of arrival to a facility" as the guideline. We believe Emergency Departments should be included in this requirement, although we recognize this position may be controversial. Domain 3.7 Prevention and healing strategies that should be avoided: Line 663 We recommend examples of solutions be included in addition to undiluted hydrogen peroxide, such as Dakin's solution, Betadine, etc. and other antiseptics commonly used on pressure ulcers.	Thank you for your comment.
196	Member, Health Professionals	Caitlin Connolly, American Geriatrics	4	Domain 3: Prevention and Healing	The 8 hour assessment rule is, while difficult to achieve in some settings, critical to effective prevention.	Thank you for your comment.
197	Member, Health Professionals	Caitlin Connolly, American Geriatrics Society	4	Domain 3: Prevention and Healing	We agree with the management strategies and the list of what not to do. We think that avoiding wet to damp and damp to damp dressings may be difficult, especially in facilities with limited funds and for patients with poor reimbursement. Nonetheless, the evidence on this point is clear and should be supported.	Thank you for your comment.
201	Member, Health Plan	Rebecca Zimmermann, AHIP	4	Domain 3: Prevention and Healing	AHIP recommends additional research into the assessment and identification of populations who are at high risk for development of pressure ulcers, i.e. patients with impaired mobility related to falls, hip fractures, stroke, spinal cord injuries, etc. Measures that assess the number and severity of pressure ulcers, assess high-risk populations for pressure ulcers, and assess the ability to prevent and effectively manage ulcers should be developed. We support the eight-hour window of ulcer assessment on arrival at a facility; High-risk patients should be assessed for ulcers present on admission	Thank you for your comment.
204	Member, Provider	Rita LaReau, Bronson Methodist Hospital	4	Domain 3: Prevention and Healing	Line 541: This is reasonable and prudent. Transitions in care are a critical time for elderly patients. Determining the patient's risk is only the first step in providing bes practice. It should be completed as quickly as possible so interventions can be put in place in a timely mantter. Capezuti, E.,Zwicker, D.,Mezey, M., Fulmer, T., Gray- Miceli,D.,Kluger, M. 2008. Evidence-Based Geriatric Nursing Protocols for Best Practice, New York: NY Springer Publishing Co	Thank you for your comment.

205	Member, Provider	Rita LaReau, Bronson Methodist Hospital	4	Domain 3: Prevention and Healing	Line 547...communicate across care settings...transitions in care. Elderly are being discharged at an earlier rate because of utilization constraints which often results in unresolved problems. (HUPnet, Health care Cost and Utilization Project, Agency for Healthcare Research and Quality. (2002). Outcomes by patient and hospital characteristics for all discharges (on line). 2002)	Thank you for your comment.
206	Member, Provider	Rita LaReau, Bronson Methodist Hospital	4	Domain 3: Prevention and Healing	Line 571 Recommend: Every 12 hour skin inspection	Thank you for your comment.
207	Member, Provider	Rita LaReau, Bronson Methodist Hospital	4	Domain 3: Prevention and Healing	Line 537 Use evidenced based practice assessment tool to coplete assessment. Integrate racial differences in skin pigmentation into assessment Capezuti, E.,Zwicker, D.,Mezey, M., Fulmer, T., Gray- Miceli,D.,Kluger, M. 2008. Evidence-Based Geriatric Nursing Protocols for Best Practice, New York: NY Springer Publishing Co	Thank you for your comment.
209	Public	Jennifer Pettis, New York Association of Homes and Services for the Aging	4	Domain 3: Prevention and Healing	Below are comments are regarding lines 541-543 (the proposed 8-hour assessment window within the NQF proposed standards): Nursing homes are required to have eight hours of consecutive registered nurse (RN) staffing per day (see regulation F354 in Appendix PP of the State Operations Manual which is available at the following link: http://cms.hhs.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf). In states in which assessment is, due to state practice act, limited to RNs, it is possible that the 8-hour proposed assessment timeframe would not be able to be met. In such facilities, for instance, with a new admission with a wound, an LPN would inititate treatment as ordered by the medical provider for the wound and communicate any other apparent adverse resident findings to the proivder or to an RN on call. The full assessment would be completed by the RN within 24 hours; the risk assessment would be completed by that time as well. Nursing homes without 24-hour RN avalability (in a state in which assessment must be done by the RN, per state practice act) should have policies which outline how apprpriate care is delivered in the absence of the RN, including screenings by the LPN and communication with the provider and/or RN to determine when a change in the resident plan of care is required. Thank you for the opportunity offer comment on the proposed standards.	Thank you for your comment.

216	Member, QMRI	Ruth Kirschstin, National Institutes of Health	4	Domain 3: Prevention and Healing	We like to add the comment that under the therapies to avoid section, some providers still have the idea that topical use of anti-acids, e.g. Maalox, can be helpful on wounds. It might be helpful if this document reviewed different topical agents that should or should not be used on pressure wounds	Thank you for your comment.
223	Member, Health Plan	Jed Weissberg, Kaiser Permanente	4	Domain 3: Prevention and Healing	Domain 3.1 – Kaiser Permanente agrees with the expectation that patients' skin integrity is assessed. That said, we recommend more NQF discussions with key stakeholder groups across the care continuum before any changes are made regarding the window of eight hours of arrival at the ED.	Thank you for your comment.
224	Member, Health Plan	Jed Weissberg, Kaiser Permanente	4	Domain 3: Prevention and Healing	Domain 3.3 – We agree with the overall prevention strategies and also propose including prevention strategies associated with pre-op assessment of nutritional status where the screening of high-risk patients before surgery is essential. Furthermore, we suggest that the NQF give consideration to recommending hourly rounding as an evidence-based practice for the prevention of pressure ulcers.	Thank you for your comment.
234	Public	Julia Ringhofer, Scripps Mercy Hospital	4	Domain 3: Prevention and Healing	Since ulcers can form in a few hours perhaps it could be a a recommendation to perform the subscale of mobility on the Braden scale and if 1 or 2 on the scale initiate basic prevention measures and set that standard to be within 4 hours of entry into the institution. The full risk assessment and skin observations could then be set for 8-12 hours to accommodate those facililities with 12 hour shifts. Or if not completed by the end of the 1st nursing shift of pt time in institution..then will be completed within the half of that second shift…. It makes sense to link the risk and skin assessments with bathing time. Risk Awareness At Scripps Health Care in San Diego,we launched a laminated skin risk sign posted at the head of bed for those at risk or with a pressure ulcer.It seems that this approach could be adopted across all inpt. health care institutions. Perhaps the symbol or a symbol could even be adopted as a universal or national symbol and then all of the health care team could be trained to understand what the symbol means.I will attach the poster we presented at the recent NPUAP.	Thank you for your comment.

236	Public	Lia van Rijswijk, La Salle University, School of Nursing and Health Sciences,Ostomy Wound Management	4	Domain 3: Prevention and Healing	Plan of Care (if healing is goal of care) While research to predict healing of pressure ulcers is definitely needed, as described in the report, evidence dating back to 1993 from venous ulcers (J.Family Practice, attached), full thickness pressure ulcers (van Rijswijk & Polansky, attached), and diabetic foot ulcers (Sheehan, attached) is remarkably consistent. In all studies, a 30 to 40% reduction in ulcer area after 2 to 3 weeks or a 50% reduction after 4 weeks of care is a significant predictor of healing. Even though pressure ulcer data is limited and more research is needed, both the strength of the evidence itself (see Kaplan Meier curves in WOUNDS publication), the consistency of findings from other chronic wounds, and overall outcomes data (see attached Kerstein reference) indicate that suggestions for a plan of care should include benchmarks. A conservative interpretation of all available data (and one that has been included in several texts) would read: “After 4 weeks, the plan of care should be revised if the wound has not reduced 30 to 50% in size.” Please note that this would apply to full thickness wounds only. Partial thickness pressure ulcers heal much more expediently if managed appropriately (have references if you need them). Including these evidence-based benchmarks will prevent the anguish and pain of languishing wounds caused by ineffective interventions. Thank you for your consideration and please do not hesitate to contact me if you have any questions or if I can be of further assistance.	Thank you for your comment.
240	Public	Robert Green, UnitedHealthcare	4	Domain 3: Prevention and Healing	Prevention and Healing: NQF specifically is seeking comment on whether the requirement for a head to toe assessment of the skin of a patient in 8 hours from admission is a good time window to use to assess prevention activities. We concur that the head-to-toe skin assessment performance within 8 hours of admission is an important prevention strategy and is reasonable for a facility. The rest of the recommendations in this section on prevention and healing are reasonable. If you wish to discuss our recommendation further, please feel free to contact me directly. Thank you for your consideration of our comments.	Thank you for your comment.

250	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	4	Domain 3: Prevention and Healing	Domain 3.1 Assessment NPUAP supports the idea of expecting full assessment of skin at the time of admission. This expectation can be easier said than done however; some patients are extremely low risk such as obstetric patients and outpatients for surgery. Therefore, the broad over-generalized statement needs refinement to those at risk now or who will likely be at risk of pressure ulcers. We do not know of a "head-to-toe pressure ulcer risk assessment"; head-to-toe assessments are modified physical examinations. The reference to the PUSH tool also seems out of place, since the PUSH tool measures pressure ulcers not pressure ulcer risk. NPUAP does not believe that a rigid time frame for assessment can be mandated, especially to acute care hospitals. Reasonable parameters for assessment of risk will be published in the International Guidelines for Pressure Ulcer Prevention early this summer.	Thank you for your comment.
251	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	4	Domain 3: Prevention and Healing	Domain 3.2 Training and Education NPUAP supports the concept of training and education. NPUAP has had a published core curriculum for prevention and treatment of pressure ulcers in nursing curricula for over 10 years.	Thank you for your comment.
252	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	4	Domain 3: Prevention and Healing	Domain 3.3 Prevention Strategies NPUAP supports the principles of pressure ulcer prevention listed in the document. The wording on number 4 is unclear; it states "turn for bed and chair". Perhaps you meant "turning and/or repositioning schedules"? More specifics for pressure ulcer prevention in usual and unusual patients will be published in the International Guidelines for Pressure Ulcer Prevention early this summer.	Thank you for your comment.
253	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	4	Domain 3: Prevention and Healing	Domain 3.4 Care Transitions While NPUAP supports the concept NQF relates in the section on transition, we stand on our previous objections to portions of this document. The proposed data set for communication would be largely driven by a standard transfer document to replace document 3008 in current use. We are surprised that such a recommendation is not in this report.	Thank you for your comment.

254	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	4	Domain 3: Prevention and Healing	Domain 3.5 Plan of Care NPUAP supports the notions detailed in this section but would add many other aspects of planning care, including compliance or likely adherence to the plan, ability to adhere to the plan when considering cost of care, loss of wages, loss of independence, ability to procure needed supplies. The second statement indicates that a "realistic plan of care be developed" and again, realistic is a complex term for which much more discussion should be included, especially if this care planning would become one of the quality measures.	Thank you for your comment.
255	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	4	Domain 3: Prevention and Healing	Domain 3.6 Wound Management NPUAP agrees with the list of wound management strategies; if it is understood that each and every treatment begins with the patient's desires. It is unclear how these management strategies will be used as data points in a quality measurement. Phrases such as is written "Careful consideration of medications or therapies that may inhibit wound healing" does not guide care or set a quality measurement. From a clinical perspective, antineoplastics and antiinflammatories are given to control underlying disease and seldom can be or should be adjusted to promote healing. Clinicians often instruct patients that healing will be delayed or that the development of infection may be more difficult to control because of these underlying treatments. If the wound fails to heal or make progress toward healing in a certain amount of time appears as though it could be a quality measure, however no such language is found in the document. This outcome would be analogous to the measurement of glycated hemoglobin in diabetes.	Thank you for your comment.
256	Public	Laura Edsberg, National Pressure Ulcer Advisory Panel	4	Domain 3: Prevention and Healing	Domain 3.7 Strategies to avoid NPUAP in general agrees with the list of "don'ts", but again we are not clear on how these issues would or could become quality measures. NPUAP will be publishing the new International Guidelines on Pressure Ulcer Treatment which will include research guided interventions on appropriate seat cushion cut-outs for pressure redistribution, sheepskins that do prevent ulcers and gauze based negative pressure therapy.	Thank you for your comment.
15	Public	Denise Elber, Parma Hospital	5	Three Methods to Measure Area Encompassing Wound	This is somewhat of an age old problem. I have obviously incorporated a combination of A and B. Using longest length with head as orientation and perpendicular longest width. This has been easier to understand for staff responsible in an acute setting. Even in unusual areas the head can be used as an orientation. I have not had opportunity to observe electronic programs that measure wounds for surface areas. To move and stretch skin or not to move? Should be documented as provides additonal information for comparison.	Thank you for your comment.

26	Public	Colleen Karvonen, UWMC	5	Three Methods to Measure Area Encompassing Wound	342-375 I am in favor of using the longest part of the wound as the length regardless of head to toe orientation. Along with that, I am in favor of measuring width as widest part perpendicular to the length, and depth as deepest part straight down to the wound bed rather than at an angle. I think this method gives more consistency in wound measurement, especially when it is difficult to determine exact anatomical orientation.	Thank you for your comment.
36	Public	Yanick Martelly-Kebreau, Visiting Nurse Service of NY	5	Three Methods to Measure Area Encompassing Wound	Wound measurement: I like the measuring technique for the length on slide 5 Length C-I would recommend similar technique for the width-The depth is the deepest part of the wound-Sinus/tunneling and undermining can remain separate or can be considered to be the depth (I am neutral on that one). 367- I gree that exudate amount is not always a sign of improvement but can be a sign of deterioration (increase exudate)	Thank you for your comment.
66	Public	Angela Stokes, Truman Medical Center	5	Three Methods to Measure Area Encompassing Wound	We use the head-to-toe method for measuring wounds. I think it works well. If we change it to something people aren't familiar with or have difficulty grasping, there may be more confusion and less consistency in documentation. Head -to-toe is something everyone can remember and have a handle on.	Thank you for your comment.
94	Public	Connie Blazek, Luther Hospital	5	Three Methods to Measure Area Encompassing Wound	Line 352-This is the method used at our hospital.	Thank you for your comment.
116	Member, Purchaser	Gaye Fortner, HealthCare 21 Business Coalition	5	Three Methods to Measure Area Encompassing Wound	For the purposes of consistency of data collection, we support the Box technique (length A), measuring the longest dimension regardless of orientation.	Thank you for your comment.
122	Member, Purchaser	Shari Ling, CMS/OCSQ/QMHAG	5	Three Methods to Measure Area Encompassing Wound	Three techniques were discussed: box technique; Best area and Vertical box. Is there evidence to support one measurement technique over the other in terms of accuracy, reliability or usability? Is one method preferred by NPUAP, WOCN and if so, why? The environmental scan does not adequately address this comparison. However, the references provided in the environmental scan and others suggest that tracing or impression recording provides the best clinimetric properties. That the web-based method yielding excellent kappa statistics speaks to the importance of gold standard examples during training. Is there precedence for using scalable photographs in practice?	Thank you for your comment.

134	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	5	Three Methods to Measure Area Encompassing Wound	Most experts at Mayo Clinic would support the recommended technique to measure a pressure ulcer (Best Area, length B). We would add a statement to the width to clarify the technique: To measure a pressure ulcer use: 1. Length: longest length, head-to-toe 2. Width: LONGEST MEASURE, perpendicular to length 3. Depth: deepest vertical depth - dipstick in multiple areas to obtain deepest depth 4. Area: encompassing the pressure ulcer	Thank you for your comment.
155	Member, Health Professionals	Lea Anne Gardner RN PhD (on behalf of the Performance Measurement Subcommittee), American College of Physicians	5	Three Methods to Measure Area Encompassing Wound	Regarding the choice of the three methods for measuring wound area, we felt that Method A "Box Technique" seems to cover the broadest area of the wound and would provide the greatest amount of information regarding the surface area.	Thank you for your comment.
183	Member, Consumer	Carol Sakala, Childbirth Connection	5	Three Methods to Measure Area Encompassing Wound	For the purposes of consistency of data collection, we support the Box technique (length A), measuring the longest dimension regardless of orientation.	Thank you for your comment.
192	Member, Provider	Belinda Ireland, BJC HealthCare	5	Three Methods to Measure Area Encompassing Wound	The importance of a single standard measurement is essential for quality measurement. Also important is the need for whatever measurement method is selected to be easy to do and to get the same measurement when done repeatedly by different providers, since progression is an important part of the measurement goal. We support whatever method is most likely to achieve that goal and recommend pilot testing of it before use in public reporting or reimbursement based on performance around its use.	Thank you for your comment.
212	Public	Janis Harrison, Harrison WOC Services	5	Three Methods to Measure Area Encompassing Wound	I find the 'box' technique the easiest to teach and to keep the measurements recording in the same manner with different staff measuring.	Thank you for your comment.
213	Public	Joni Boese, Buena Vista Regional Medical Center	5	Three Methods to Measure Area Encompassing Wound	As a practicing WOC Nurse for 23 years, I would like to vote for the Box diagram for measuring pressure ulcers. I think this one offers the most consistency with different practiitioners. Thank you for your time.	Thank you for your comment.
218	Public	Kim Kopp, Cass County Memorial Hospital	5	Three Methods to Measure Area Encompassing Wound	I currently am doing the " Box" technique in my practice and is what I have frequently taught the students that I see. So I would vote to use that method.	Thank you for your comment.

226	Public	Sarah Holden-Mount, American Medical Technologies	5	Three Methods to Measure Area Encompassing Wound	In regards to your discussion on the three different ways to measure. In all honesty, the verbiage used and the methods to describe is confusing. The section titled "To measure a pressure ulcer use:...." was far easier to follow, and duplicate. We also like to include a clock, as appropriate, for reference in measurement. In general, we feel that wound measurement will always have a "subjective" portion, and one way we can avoid common questions or misunderstanding is simple descriptors to how the measurement was performed. For example, a descriptor such as position of the resident, can be a descriptor that may avoid confusion, and allow the next person the ability to duplicate the measurement taken.	Thank you for your comment.
229	Public	Clinical Nurse Specialist Team, University of California, San Francisco Medical Center	5	Three Methods to Measure Area Encompassing Wound	2. Methods of Measurement & Assessment timeframe We recommend longest length and width (using landmarks of head to toe as the orientation for length). We are not sure why lines 359 and 360 are present. Although minor, we recommend consistent use of assessment terms such as “comprehensive assessments” (line 545). The previous bullet point on lines 541-542 calls this “head to toe skin assessment and the pressure ulcer risk assessment” and only later is the comprehensive term used. Line 539: recommend change to “screen all patients for pressure ulcer risk” rather than using “head to toe” regarding p. ulcer risk assessment to minimize confusion.	Thank you for your comment.
258	Member, Health Professionals	As requested in the report our comments regarding the three methods of pressure ulcer measurement are outlined below.	5	Three Methods to Measure Area Encompassing Wound	As requested in the report our comments regarding the three methods of pressure ulcer measurement are outlined below. While the use of one of these methods of pressure ulcer measurement would lend standardization of wound assessment across the care continuum, we believe the measurement focus should emphazie accurate and complete documentation of the wound characteristics rather than specific technique. As outlined in the framework, these characteristics would include the recommended elements of length, width, depth, tissue type percentage and undermining/tunneling. We appreciate the opportunity to comment.	Thank you for your comment.
17	Public	Denise Elber, Parma Hospital	6	Comprehensive Skin Assessment at Admission	I think 8 hours would be maximum. If pressure wounds can start in as little as 20 minutes then we need to assess risk and get interventions in place as soon as possible. From point of entry i.e. ED.	Thank you for your comment.
67	Public	Angela Stokes, Truman Medical Center	6	Comprehensive Skin Assessment at Admission	We do a thorough skin assessment within 8 hours of admission. We struggle with our ED patients who may wait for up to 24 hours to get an inpatient bed. But 8 hours should be the standard to see if there is some type of skin breakdown occuring because early intervention will be the key.	Thank you for your comment.

101	Member, Health Plan	Catherine MacLean, WellPoint, Inc	6	Comprehensive Skin Assessment at Admission	Recommend head to toe assessment within 8 hours be directed at high risk patients/units. Review present on admission for all high risk patients Recommend setting different time standards and repetitive assessments based on risk level of patients	Thank you for your comment.
110	Public	Teresa Mota, Quality Partners of Rhode Island	6	Comprehensive Skin Assessment at Admission	Agree with comprehensive skin assessment on admission (within 8 hours).	Thank you for your comment.
117	Member, Purchaser	Gaye Fortner, HealthCare 21 Business Coalitino	6	Comprehensive Skin Assessment at Admission	The 8-hour assessment window for doing head-to-toe skin assessment is inappropriate. Eight hours is too long to allow patients to go without doing an assessment. For the frailest patients, pressure ulcers can occur in as little as two hours. I recommend shortening the assessment time to two hours.	Thank you for your comment.
123	Member, Purchaser	Shari Ling, CMS/OCSQ/QMHAG	6	Comprehensive Skin Assessment at Admission	The proposed 8-hour timeframe for a comprehensive head-to-toe assessment may be reasonable and could allow for detection of new ulcers that were initiated in the transferring facility, but what is this time requirement based on? The supporting evidence for the 8-hour timeframe should be provided. Furthermore, whether this 8-hour time frame might apply to the home-care requires discussion.	Thank you for your comment.
139	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	6	Comprehensive Skin Assessment at Admission	Mayo Clinic supports the 8 hour timeframe for a head-to-toe skin assessment and a pressure ulcer risk assessment in most circumstances. From the hospital perspective, there may need to be a few exceptions: For these assessments, consideration should be given to not screen patients from select low risk populations (e.g. normal obstetrics, mobile and healthy individuals.) The ED assessment may need more discussion as some patients may need this assessment or a modified assessment, while others may not need the assessment at all (a healthy 12 year old child with an acute infection). Different populations have different needs. Also, some risk factors have long term influence (days) on risk, like moisture and nutrition, while others have short term influence (hours) like paralysis, ischemia and loss of perception. We would recommend research on an acute risk assessment tool for the ED patient which should be completed within 2-4 hours of arrival, while a complete risk assessment can be completed later, if admitted. The concern comes primarily from caring for persons with paralysis. They don't need someone to intervene regarding their nutrition during their ED visit. They need someone to assess their mobility and compensate for the lack thereof when in the ED environment.	Thank you for your comment.

140	Member, Provider	Jacqueline Attlesey-Pries, Mayo Clinic	6	Comprehensive Skin Assessment at Admission	Some very critical patients may need to go from an ED right to an OR. Ideally such patients will be examined head to toe, but whether the formal assessment by nursing can be accomplished and documented may not be feasible. For example, a trauma patient, goes to surgery, and cannot be fully assessed due to hemodynamic instability. Many hospitals have outpatient based areas. We assume these areas would be excluded unless the patient is actually admitted for inpatient care.	Thank you for your comment.
184	Member, Consumer	Carol Sakala, Childbirth Connection	6	Comprehensive Skin Assessment at Admission	The 8-hour assessment window for doing head-to-toe skin assessment is inappropriate. Eight hours is way too long to allow patients to go without doing an assessment. For the frailest patients, pressure ulcers can occur in as little as two hours. We would strongly recommend shortening the assessment time to two hours.	Thank you for your comment.
193	Member, Provider	Belinda Ireland, BJC HealthCare	6	Comprehensive Skin Assessment at Admission	In the absence of evidence it is difficult to select a specific time. Although we know 8 hours will be difficult for large hospitals with busy ED to achieve, given that we know that the sooner the patient is assessed and diagnosed with pressure ulcer or high risk of development, the sooner we can implement processes to reduce progression or occurence, we recognize the importance of prompt assessment. Again we recommend pilot testing before use in public reporting or reimbursement based on performance around its use.	Thank you for your comment.
227	Public	Sarah Holden-Mount, American Medical Technologies	6	Comprehensive Skin Assessment at Admission	Lastly, we agree with your window of time of 8 hours for a head to toe skin assessment and risk assessment upon admission. We would suggest adding verbiage to the effect of "this is the maximum amount suggested time, these tools should be preformed as soon as possible upon admission, but not to exceed an 8 hour time window." Thank you for sharing the draft document with the public, and seeking comments. We look forward to reviewing the final document upon completion.	Thank you for your comment.
230	Public	Clinical Nurse Specialist Team, University of California, San Francisco Medical Center	6	Comprehensive Skin Assessment at Admission	We agree with the full skin assessment and risk for PU within 8-hrs, but we recommend clarification of the start time of this 8-hr window. For the emergency department, we recommend the “time to room” be used as the start time for the 8-hr window. On lines 541-544 it states, “including arrival at the emergency dept”, which can be a variable length of time before a nurse sees the patient (e.g. waiting room time of 6 hrs leaves 2 hrs for full assessment and risk evaluation). We recommend a similar clarification for the perioperative area as patients come to the preoperative area, wait (varying lengths of time), are seen by preop RN and then go to surgery. We also recommend use of “time to room” which is the time the patient goes to the area where the RN begins preoperative assessment and preparation.	Thank you for your comment.

