Midland Burn

Operational Delivery Network

Midlands Burn Operational Delivery Network Adult and Paediatric Nutrition Audit Tool

Introduction

The Midlands Burn Operational Delivery Network (MB ODN) developed Guidelines for the Nutritional Management of Adults and Paediatrics Patients within the Midlands Network.

Purpose

The purpose of this document is to provide a mechanism for reviewing the quality of nutritional assessment, management and documentation for adult and paediatric burn injured patients.

Guidelines for completion

- Nominate individuals (MDT participation) within each service to undertake the audit
- Complete the details at the top of the form
- **Please ensure a selection of in-patient notes and notes of out-patients that are being seen in Consultant follow up clinic are reviewed:**
    - **Select ten patients in your clinical area.**
    - **Notes of at least 3 patients who have been tube fed should be included** (Moderate / Severe burn injured patient)
    - **2 – 3 out-patients** (being seen in Consultant follow up clinic)
- Patients Medical, Dietetic and Nursing records need to be reviewed at time of audit.
- Place the hospital number at the top of each column
- The audit form relates to the recommendations set out in The Nutrition and Dietetic Journey for the Burn Injured Patient; Guidelines for Nutritional Management of Adults and Paediatrics
- Within each section there are a number of statements which are the performance indicators
- In the column next to each statement place a √ for yes and an X for no. In the few occasions where the statement is not applicable then N/A can be put but an explanation of why the statement is not applicable to that patient must be documented **(see page 6)**
- When you have completed up to ten patients, review each performance indicator for each patient
- At the end of each row add up all the √ and X
- If you obtain 100% √ then the result is **green** (this excludes any N/A's)
- If you obtain 100% X then the result is **red** (this excludes any N/A's)
- Any other result is **amber**
- Key –

Green	The standard is good and needs to be maintained
Amber	This indicates that consistency is required to raise and maintain the standard to green. Further education may be required. Any development/ training needs should be identified and addressed within an agreed action plan and timescale.
Red	The standard of nutritional and dietetic assessment, management and documentation is unacceptable and development/ training needs should be identified and addressed within an agreed action plan and timescale.

Midlands Burn ODN Nutritional Management of Adults and Paediatrics Audit Tool

Ward/Hospital …… Date ……. Time …… Completed by ……

ADULT / PAEDIATRIC (please circle)	1	2	3	4	5	6	7	8	9	10	**Green**	**Amber**	**Red**
1. Hospital number:													
2. Please state if Minor / Moderate / Severe burn													
3. All patients' weight and height are measured and documented on admission. **If one missing please write which one completed: W or H** <u>Paediatric patients</u> Measurements are plotted on a percentile growth chart in patients medical / nursing records													
4 i. All patients have a Nutritional Screening Tool completed within 24 hours of admission. **ii**. Screening tool is repeated weekly													
5. All patients' baseline nutritional bloods have been measured on admission. This must include: U&Es, Alb, LFTs, Full Blood Count, CRP Ca, Mg and PO4 **<u>Moderate and severe burn injured</u>** Baseline trace elements of Copper, Zinc and Selerium have been measured on admission and repeated weekly													

6 i. Dietitian to assess patient within one working day of receipt of referral **ii**. Recommendations to be documented in medical notes													
7. Evidence dietitian has given verbal +/- written advice to patient / carer to promote high protein diet and maintain regular bowel habits. (May be recorded in medical notes)													
8. Patients who require food and fluid balance monitoring as directed by dietitian / screening tool have their charts fully completed daily													
9. Adults and Paediatrics **i**. If burn ≥15% a feeding tube is placed and feeding commenced within 24-48 hrs of admission **ii**. Dietitian will provide a written tube feeding regimen stating type, rate and volume of feed within 1 working day of receipt of referral													
10. All gastrically **(NG**) fed patients have their feed stopped for no longer **i**. Than indicated on feeding regimen **ii**. Than 6 hours before last anaesthetic procedure													
11. Confirmation of position of NG / NJ tube is documented each time feed is started. Review records since tube feeding commenced													
12. Patient bowel management habits are recorded on admission in nursing assessment													

13. Bowel habits monitored and recorded daily Review records since admission													
14. Speech and Language Therapist to complete patient assessment within 48 hours of receipt of referral Recommendations to be documented in medical notes													
15. All patients are weighed on discharge and this is documented in the medical and nursing notes													
16. All patients' weight (and height / length for paediatrics) is measured and recorded by Clinic staff at every Consultant outpatient appointment.													

Reasons for N/A (N.B. these should be infrequent exceptions)

Audit criteria number	Patient number	Reason the criterion is not applicable

Any other comments: