Benchmarks for children’s orthopaedic nursing care

RCN guidance
Acknowledgements

The RCN Paediatric Orthopaedic Special Interest Group (POSIG) would like to thank all the contributors for their input in developing the benchmarks.

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Introduction

This document provides a portfolio of evidenced-based benchmarks, which define best practice in key elements of paediatric orthopaedic nursing care. They have been devised by a core team of expert, experienced nurses from the paediatric orthopaedic special interest group (POSIG) to identify the optimal care management for children and young people with an orthopaedic condition. The benchmarks are based on the format of The Essence of Care (DH, 2001) to help practitioners 'to identify best practice and to develop action plans to improve care'. The statements and indicators are aimed to stimulate discussion, help measure individual practice and guide staff to review the various issues surrounding each benchmark. The benchmarks are easy to use and auditable, and can be used to inform, update and change practice.
Pre-op assessment

Pre-operative assessment for child/young person admitted for elective orthopaedic surgery

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**Factor 2: Practitioner competence**

Child/young person is assessed by practitioners who do not have the required specific knowledge and expertise.

Benchmark of best practice

Child/young person is assessed by a practitioner who has the knowledge and expertise, and remains up-to-date.

**Indicators of best practice for factor 2**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- knowledge and expertise required for completing screening and assessment and the process for maintaining and remaining up-to-date
- put in place mechanisms to assess the competence of the screeners and assessors
- access specialist assessment if required
- document assessment for use by the caring team.

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**Factor 1: Screening and assessment**

Child/young person is not given the opportunity to come for a pre-assessment appointment.

Benchmark of best practice

Child/young person to be admitted for elective surgery is given the opportunity to come for a pre-assessment appointment.

**Indicators of best practice for factor 1**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- assessment of children/young people to identify potential risk and the initiation of a discharge plan
- adequacy and inclusion of the components of the screening assessment and what tools are used
- documentation of the screening assessment
- screening assessment is carried out within acceptable time frame
- inclusion of a manual handling assessment
- evidence-base used for assessment is current.
**Factor 3: Informing child/young person and carers**

**Benchmark of best practice**
Child/young person and carers have access to information and have the opportunity to discuss this with a registered practitioner at assessment.

**Indicators of best practice for factor 3**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- range of information available and its format to meet children/young peoples’ or carers’ individual needs, such as language, tapes, videos and leaflets
- evidence-base for the information
- children/young peoples’ understanding of the information is verified and choices are documented
- record sharing and understanding of information.

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**Factor 4: Implementation of an individualised plan**

**Benchmark of best practice**
The assessment leads to an individualised plan that is fully implemented in partnership with the multidisciplinary team (MDT), child/young person and carers.

**Indicators of best practice for factor 4**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- barriers to the implementation of planned care and how variance is recorded
- document how the multidisciplinary team is involved
- how the parents and child/young person are involved.

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**References**


Cast care

Care of child/young person in a cast

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**Factor 1:** Education and training

**Indicators of best practice for factor 1**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:
- nurses have attended formal training by a qualified and competent practitioner
- nurses have completed practical competencies with annual updates and these are documented
- trained in neurovascular observations (refer to benchmark 3) and cast complication.

**Benchmark of best practice**
Child/young person is cared for by nurses who have knowledge and expertise in all aspects of caring for a cast.

**Factor 2:** Patient care

**Benchmark of best practice**
Child/young person receives care from competent and knowledgeable nurses and has access to MDT for additional care and support.

**Indicators of best practice for factor 2**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:
- type of cast – plaster of Paris, synthetic – and its specific care
- handling and positioning of cast – upper/lower limb, hip spica, broomstick plasters etc
- cast is handled carefully when wet to avoid undue pressure and potential damage
- carry out regular assessments i.e. neurovascular observations, ooze, tightness, sharp edges, whether loose or cracked. Take appropriate action
- documentation of above
- daily review by MDT e.g. physiotherapist, occupational therapist, as needed.

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Factor 3: Upper body cast

**Indicators of best practice for factor 3**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- type of cast e.g. backslab/full and specific advice for care
- assist with hygiene and feeding needs. Address the issues of education needs (e.g. writing, school attendance), limitations to sports activities
- appropriate aids for immobilising i.e. collar and cuff/ sling, appropriate for the type of cast
- education/information needs regarding neurovascular observations and advice on elevating upper limb(s) when at rest (see neurovascular assessment benchmark)
- documentation of care provided/information given etc.
- offer coloured cast.

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Factor 4: Lower body cast

**Indicators of best practice for factor 4**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- type of cast and implications to care e.g. long leg cast, backslab, hip spica
- personal hygiene is attended to by nursing team and taught to the family
- care needs, particularly manual handling and mobility needs, are assessed, documented and taught by appropriate practitioner e.g. nursing staff, occupational therapist / physiotherapist
- pressure area care and regular turning of child in cast, as appropriate for type of cast e.g. hip spica cast
- patient taught safe use of crutches/Zimmer frame/wheelchair/buggy by appropriate practitioner
- offer coloured cast and crutches.

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**Factor 5:** Discharge planning

**Indicators of best practice for factor 5**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- **Implement care plan at earliest opportunity e.g. at pre-admission/admission.** Discharge plan is documented.
- **Document and perform the nursing assessment appropriately i.e. neurovascular observations, ooze, tightness, sharp edges, looseness, cracked cast.**
- **Address and evaluate the family’s needs.** Give advice (verbal and written) and education and information about neurovascular observations, mobility and cast care.
- **Provide care for child by appropriately trained and experienced MDT.**

**Benchmark of best practice**

Child/young person is cared for by MDT and discharge planning is evident.

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**References**


Neurovascular assessment

Neurovascular assessment (NVA) for child/young person at risk of developing compartment syndrome

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Factor 1: Education and competence

Health professionals fail to assess the child/young person's clinical need for NVA and have not received education relating to compartment syndrome or training in the correct use of the NVA tool.

Benchmark of best practice

The health professional has received appropriate education and training in the assessment of the child/young person's clinical need for NVA, the completion of the NVA tool and can demonstrate knowledge relating to compartment syndrome.

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Indicators of best practice for factor 1

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- clinical need for individual neurovascular assessment and the appropriate frequency of observations
- 'best placed' health care professional to make the decision for frequency of NVA and the qualifications or level of experience they possess

- any clinical protocols, guidelines or literature that exists to guide this process
- training required to achieve knowledge and competence relating to this factor, the frequency of training updates and how this will be demonstrated.
Factor 2: Recording and documentation

The NVA tool is incorrectly or only partially completed and there is no documentation in the child/young person’s nursing notes relating to the completion of, or findings from the NVA tool.

Benchmark of best practice
The NVA tool is completed correctly and at the predetermined interval times, with evidence of documentation in the child/young person’s nursing records of completion and of the clinical findings.

Indicators of best practice for factor 2
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

✦ educational needs of the health professional completing the NVA tool
✦ importance of documenting why a part of the tool is not completed e.g. plaster in situ
✦ legal implications of documenting nursing practice
✦ who determines interval times for completion of the NVA tool.

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Factor 3: Communication and information

The child/young person and parents are not informed about the necessity of NVA.

Benchmark of best practice
The child/young person requiring NVA assessment and their parents have been informed of the necessity and understand the rationale for NVA.

Indicators of best practice for factor 3
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

✦ what information child/young person and parents require and their communication needs
✦ appropriate format for the information.

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**Factor 4: Clinical action**

The nurse fails to respond appropriately and does not refer or take clinical action when a neurovascular cause for concern is identified.

**Indicators of best practice for factor 4**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- optimal clinical action for each indicator of potential compartment syndrome
- whether this differs according to experience and qualification of the health care professional
- appropriate health professional from whom the nurse should seek further advice, if neurovascular compromise is a concern
- action taken if the referral is unsuccessful and the clinical cause of concern remains
- documentation of the event in the medical and nursing notes.

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**Factor 5: Discharge planning**

There is no evidence of discharge planning relating to the ongoing neurovascular care of the child.

**Indicators of best practice for factor 5**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- content of the information given and in what format
- to whom it should be given
- where this should be documented.

**Score**

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References


Swain R and Ross D (1999) Lower extremity compartment syndrome: when to suspect acute or chronic pressure build up, Post Graduate Medicine, 105(3), pp.159-168.


Factor 1: Education and the application of traction

Traction application and maintenance for the clinical management of children with fractures or pre or post-orthopaedic surgery

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Health care professionals have not received education relating to the application of traction.

Benchmark of best practice
The health care professional has received appropriate education and training in the application of traction and can demonstrate the skill competently.

Indicators of best practice for factor 1
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- ‘best placed’ health care professional to teach and assess staff competency, depending on the qualifications or level of experience they possess
- clinical protocols, guidelines or literature that exist
- training required to achieve the knowledge and
Factor 2: Education, the management of traction and nursing care

Maintenance and care of the child/young person in traction is suboptimal.

Benchmark of best practice
Traction is safely maintained and the equipment is regularly checked. The child/young person receives optimal care while in traction, with evidence of documentation.

Indicators of best practice for factor 2
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- principles of safe practice in the maintenance of traction (e.g. safety checks, maintenance of traction pull, neurovascular status of limb in traction) and the availability of clinical protocols, guidelines or literature
- recognition of deterioration of child/young person’s condition due to immobility
- tools that can assist with the assessment of potential complications of immobility and traction (e.g. neurovascular compromise and pressure sores) and the preventative measures that can be used to reduce the risk (e.g. see benchmark for neurovascular care)
- recognition of child/young person’s schooling and psychological needs whilst in traction
- involvement of play specialist
- ‘best placed’ health care professional to care for the child/young person in traction
- legal implications of documenting nursing practice and the frequency of documentation for checking traction equipment and of patient clinical reviews.

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**Factor 3: Communication and information**

**Benchmark of best practice**
Information about the necessity for traction has been given to the child/young person and their carers verbally and is supported with a written leaflet, so that they understand the rationale for treatment.

**Indicators of best practice for factor 3**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- what information parents and the child/young person require
- appropriate format of the information.

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**References**


Pin site care

Care of pin sites for child/young person with an external fixator

Factor 1: Screening and assessment

The health professional fails to assess correctly for evidence of potential pin site infection and has not received the relevant education and training.

Benchmark of best practice
The health care professional has received appropriate education and training in the assessment for signs of potential pin site infection and can demonstrate this knowledge and competence.

Indicators of best practice for factor 1
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- signs of potential pin site infection through a consensus of opinion and as described in the literature
- training needs of the nurse in assessing the patient
- any clinical protocols, guidelines or literature that exist to guide this process.
Factor 2: Education

The child/young person and parents are not taught the signs of pin site infection or informed as to what action they should take if a pin infection is suspected.

Benchmark of best practice
The child/young person and parents are knowledgeable in determining the signs of potential pin infection and understand rationale for prompt intervention. They have been given an action plan for treatment if pin infection is suspected.

Indicators of best practice for factor 2
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- the provision of information that parents and children require
- that information is given in an appropriate format.

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Factor 3: Evidence, knowledge and competence

An evidence-based guideline is not available for health professionals to guide their practice. Pin site care is performed based on tradition.

Benchmark of best practice
An evidence-based guideline for best practice in pin site care is available and health professionals can demonstrate knowledge and competence in performing pin site care.

Indicators of best practice for factor 3
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- literature that supports best practice in pin site care
- availability of a guideline for practice
- frequency for reviewing the guideline.

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Factor 4: Clinical care

The nurse fails to respond appropriately and does not refer or take clinical action when a pin site infection is evident.

Benchmark of best practice
When a pin site infection is evident the nurse takes effective and appropriate clinical action.

Indicators of best practice for factor 4
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

✦ rationale for quick and effective treatment of actual or potential pin site infection
✦ optimal clinical action and drug therapy for early and late signs of pin site infection
✦ documentation of clinical findings and actions taken
✦ potential for improving practice-based audit findings.

Factor 5: Discharge planning

There is no evidence of discharge planning relating to the information given to the child/young person and carers to manage pin sites at home.

Benchmark of best practice
There is evidence that documentation was given to the carers and child/young person with verbal and written information regarding pin site care.

Indicators of best practice for factor 5
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

✦ information that should be given
✦ format of the information
✦ documenting that information has been given to the parents and child/young person.

References


Kirchner (K) wire removal

Removal of percutaneous K wires from child/young person in an outpatient setting, following fixation of a fracture

**Factor 1: Competency and knowledge**

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**Benchmark of best practice**

The procedure is performed by an inexperienced practitioner with no paediatric or orthopaedic knowledge and skills.

**Indicators of best practice for factor 1**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- level of experience, education and training needs for a practitioner to be competent
- assessment of the practitioner and by whom
- guidelines and evidence-base for practitioner assessment.

**Factor 2: Preparation of child/young person and carers**

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**Benchmark of best practice**

The child/young person and their carers do not receive any information relating to the procedure of K wire removal.

**Indicators of best practice for factor 2**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- putting in place evidenced-based guidelines for appropriate selection of children/young people for wire removal in outpatients
- what guidelines exist for appropriate pain relief for the child/young person e.g. simple analgesia and/or Entonox (gas and air)
- advising parents/carers appropriately on pre-procedural pain relief
- the information needs of the child/young person and their family, the format of the information and the timing of when to give the information.
- the involvement of a play specialist to facilitate child/young person’s understanding of the procedure and to engage in distraction therapy.
Factor 3: Procedure

The wires are not safely and effectively removed, traumatising the child.

**Benchmark of best practice**
A competent practitioner safely removes K wires, the child/young person’s care is individualised, evaluated and documented.

**Indicators of best practice for factor 3**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- what evidenced-based guidelines exist for the clinical procedure of removal of K wires in the outpatient setting
- what evidenced-based guidelines are available for the pain management and psychological care of the child/young person
- whether the practitioner has appropriate medical support available if required
- whether a play specialist is available for support and distraction therapy and there is provision of appropriate toys
- performing the procedure in a child-friendly environment
- that the child/young person’s notes and X-rays are made available to the practitioner
- the documentation of the procedure.

References


Bone or joint infection

Care and treatment of a child/young person with bone or joint infection

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Factor 1: Admission

The child/young person is admitted to a general children's surgical ward and cared for by staff inexperienced in the management of bone and joint infections.

Benchmark of best practice

The child/young person is admitted to a paediatric orthopaedic ward and cared for by staff experienced in managing bone and joint infections.

Indicators of best practice for factor 1

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider the:

- admission criteria for a child/young person with suspected bone/joint infection
- advantages of being admitted to a specialist paediatric orthopaedic ward with appropriately trained and competent nursing and medical staff
- availability of a paediatrician and microbiologist for advice and support
- knowledge and skills of nursing staff to ensure that infection management is explained to the child/young person and family.
**Factor 2: Assessment and screening**

**Nursing staff are not knowledgeable in the assessment and screening of the child/young person with suspected bone/joint infection.**

**Benchmark of best practice**
Nursing and medical staff are knowledgeable in the assessment and screening of the child/young person with suspected bone/joint infection.

**Indicators of best practice for factor 2**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- format for assessment and screening
- role of the nurse in ensuring that appropriate blood tests are performed at the appropriate time and the affected area is X-rayed
- role of the nurse in explaining to the child/young person and family the need for further investigations e.g. bone or ultrasound scans, MRI
- role of the nurse in monitoring vital signs for evidence of infection, the frequency and accuracy of screening observations particularly temperature and neurovascular observations.

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**Factor 3: Treatment**

**Nursing staff cannot demonstrate knowledge about the management of bone/joint infection.**

**Benchmark of best practice**
Nursing staff have the knowledge and skill to care for the child/young person with bone/joint infection and keep the child/young person and family informed.

**Indicators of best practice for factor 3**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- the availability of a local evidence-based protocol for intravenous antibiotic (IVAB) therapy.

Also, consider if nurses are:

- competent to administer IVAB
- aware of the rationale for resting and/or immobilising the affected area
- competent in preparing the child/young person for surgery and in recovery (where appropriate) and explain the process to the family
- able to recognise deterioration in condition and report to appropriate health professional.

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**Factor 4: Discharge planning**

**Indicators of best practice for factor 4**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- that the nurse regularly updates child/young person and family on clinical progress.
- that hospital and community multidisciplinary teams involved in discharge planning should include contribution of nursing and play staff where appropriate, to ensure compliance by child/young person with antibiotic regime.
- that there is evidence of documentation of discharge planning in notes, to include the written and verbal advice given, and provision of contact numbers.
- that local protocols for ongoing antibiotic therapy are followed, drugs to take home are ordered and the regime is explained to the child and family prior to discharge.
- that a nurse has arranged and explained the outpatient’s appointment and rationale for further blood tests to family.

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Spinal cord injury

Care of a child/young person following a spinal cord injury

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**Factor 1: Assessment of injury**

The child/young person sustaining a spinal cord injury is not assessed or referred for assessment.

**Benchmark of best practice**

All children/young people sustaining a potential spinal cord injury are assessed on the day of injury. The level and type of injury is determined and a referral is made to a specialist centre where appropriate.

**Indicators of best practice for factor 1**

To stimulate discussion about best practice in your comparison group, you may find it helpful to consider that:

- Knowledge and expertise for completing screening and assessment is in place and mechanisms for assessing practitioner competence exists (consider the ASIA score – the assessment of motor and sensory pathways determined by the American Spinal Injury Association). Specialist knowledge is accessed if required.
- Specialist assessment is accessed if required.

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- a patient receives a full assessment of initial injury carried out by a competent practitioner using appropriate tools, to identify potential risks.
- Guidelines for assessment are available and evidence-based.
- Injury management is defined and recorded.
Factor 2: Stabilisation

**Indicators of best practice for factor 2**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider that:

- a child/young person is immobilised by a competent practitioner prior to diagnosis in order to prevent further injury
- appropriate imaging has been carried out and a diagnosis made
- appropriate referral is made
- transfer is in an appropriate ambulance and any stabilisation prior to the transfer is carried out by a competent practitioner
- staff are appropriately trained to move patient in a safe way i.e. if unstable using a five-person turn.

**Benchmark of best practice**
Child/young person sustaining a spinal cord injury is not immobilised or stabilised before transfer.

Children/young people sustaining a spinal cord injury do not have a planned rehabilitation programme.

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Justify score marked

Factor 3: Acute care and rehabilitation programme

**Indicators of best practice for factor 3**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider that:

- acute care and rehabilitation programmes are individualised and devised by appropriate MDT professionals
- rehabilitation programmes are reviewed and updated on a regular basis
- a programme has an allocated amount of time for goal planning meetings with the patient and their family/carer and the MDT
- all members of the MDT communicate and ensure that spinal cord injury care is a team approach
- patients and their families are able to access appropriate spinal cord injury education to empower them to take control of their own care.

**Benchmark of best practice**
Child/young people sustaining a spinal cord injury have an appropriate acute care and a rehabilitation programme that is planned through a multidisciplinary approach.

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**Factor 4:** Psychological impact of a spinal cord injury

No consideration is given to the psychological impact of a spinal cord injury.

**Benchmark of best practice**
The psychological impact of a spinal cord injury to the child or young person and their family is adequately assessed and supported by an appropriate professional.

**Indicators of best practice for factor 4**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider that:

- regular MDT meetings are held to discuss any concerns between the family and/or team
- MDT, patients and their families have regular access to child and adolescent psychiatric and psychological services
- regular and ongoing assessment is carried out by the MDT
- members of the MDT have the knowledge and understanding of the psychological impact of a spinal cord injury
- specialist knowledge is accessed if required.

**Score**
Justify score marked

**Factor 5:** Discharge planning

There is no evidence of discharge planning.

**Benchmark of best practice**
Discharge planning for children and young people with spinal cord injuries starts on admission, is thorough and provides a safe and timely discharge that considers their individual needs.

**Indicators of best practice for factor 5**
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider that:

- discharge planning starts on admission with contribution from the whole MDT
- assessment of the child and family’s living arrangements is undertaken early in the admission
- appropriate outside services are accessed early in the admission
- discharge planning takes into consideration the worst possible case scenario (no improvement of condition following rehabilitation)
- discharge planning takes into equal consideration the psychological and physical aspects of a spinal cord injury, with a MDT approach to resolving both prior to discharge or arranging follow-up support
- patients are not discharged until adequate services are in place and safety can be assured.

**Score**
Justify score marked
References


Spinal surgery

Care of a child/young person undergoing elective spinal surgery

Factor 1: Pre-operative assessment

Environment is unsafe.

Benchmark of best practice
Each child or young person has the opportunity to attend a pre-operative assessment appointment for elective spinal surgery.

Indicators of best practice for factor 1
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

✦ that the pre-operative assessment benchmark is referred to
✦ that you ensure patient and family have full understanding of procedure, recovery pathway and post-surgery management
✦ the involvement of MDT
✦ the reduction of anxiety by sharing of information
✦ the start of individualised care pathway.

Score
Justify score marked

Factor 2: Nursing care plan

There is no evidence of a care plan or care has not been provided according to the plan.

Benchmark of best practice
The child/young person has a plan of care appropriate to age and need, reflecting the specific care following spinal surgery.

Indicators of best practice for factor 2
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

✦ child/young person has undergone pre-operative screening and assessment
✦ staff have appropriate knowledge to care for patient following spinal surgery, e.g. log rolling, pressure area care, positioning, bowel management, nutrition requirements, pain management, mobilising
✦ involvement of the MDT
✦ involvement of patients and parents/carers.

Score
Justify score marked
Factor 3: Pain management

There is no evidence of appropriate pain management.

Benchmark of best practice
The child/young person has their pain assessed regularly using appropriate tools and has sufficient analgesia prescribed.

Indicators of best practice for factor 3
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider:

- pain history
- whether assessment tools used are appropriate for age and competence of patients
- if pain management treatments are available and used
- the knowledge and expertise of staff and their ongoing development
- access to specialist pain service.

Score
Justify score marked

Factor 4: Post-surgical mobility

The child/young person is not mobilised in a safe or controlled manner with appropriate assistance.

Benchmark of best practice
The child/young person is mobilised post-surgery with guidance from the physiotherapist and in a safe and controlled manner.

Indicators of best practice for factor 4
To stimulate discussion about best practice in your comparison group, you may find it helpful to consider that:

- a physiotherapist should work with the patient on mobility practice for first time following surgery as per surgeons written instructions
- a patient should become mobile as soon as possible post-procedure
- if a brace is needed it should be cast and available as soon as possible
- sitting tolerance should be increased gradually
- the patient needs adequate rest between episodes of movement.

Score
Justify score marked

References


