# DAT Facilitator Guide

**Delivery Assessment Tool (DAT)**

*Improving burn services through self- assessment.*

# Guide to holding a DAT focus group discussion.

A DAT Focus Group brings together the multi disciplinary burn team to self assess their burn service against *Operational Standards for Burn Care in LMICs* using Interburns Delivery Assessment Tool (DAT).

The aim: to gain an in-depth understanding of the burn service, where it works well or where there are gaps, and use this knowledge to plan and implement targeted quality improvement initiatives.

The focus group discussion is guided by working through 10 key sections. Much of the discussion is relatively free-flowing. Everyone needs to be heard.

The facilitator's role is to generate open discussion between **all** participants, to listen to their thoughts and understand different perspectives. The facilitator is not the 'expert' – but encourages input from all.

Notetaker: This individual does not participate, but 'frees up' the facilitator, and keeps clear notes, marking down decisions taken by the group for later scoring.

The focus group responds to issues raised by others as the facilitator keeps the discussion on course.

This participatory approach ensures that a wide range of views and opinions are included in the planning of interventions and implementing change.

Tips on holding the DAT focus group discussion:

- ✓ Schedule ahead of time so the majority can attend.
- ✓ Find a quiet space for the team to sit in a circle or around a table. Everyone needs to be able to hear and be comfortable; these discussions can often take all morning or afternoon.
- ✓ Make plans for tea, coffee or snacks!
- ✓ Print out the DAT *Facilitator Guide* and DAT *Note Takers Guide* and have a pen.
- ✓ Refer to the DAT *Facilitator Guide* and add your own questions; keep questions as 'open' as possible.
- ✓ Ask the note taker to use *DAT Note Takers Guide*, circling the options you agree on.
- ✓ Encourage everyone to contribute. Don't allow a small number of individuals to dominate. If someone is quiet, ask them to give their thoughts.
- ✓ Be aware of cultural hierarchies for instance, will nurses speak up if there are Drs in the group, do you need all female and/or all male focus groups so that both genders can express an opinion?
- ✓ Ask for permission if you want to record the session to listen again.
- ✓ Inform the group about when they will receive feedback. They will be interested and are key to the process of change.

Don't forget to thank all the participants at the end of the session!

Example:
DAT Facilitator Guide

**Section 3.0 Burn Care Team**
**Sub-Section 3.3: Team Communications**

- **3.0 Burn Care Team**
- Burn MDT (3)
- Clinical Lead (1)
- Team Communications (1)
- Level of Burn Training (2)
- Access to other specialities (1)
- Overall staffing capacity (2)

**What we want to know.**

How does the burn care team meet to communicate, share information and make decisions about patient care.

Is this through regular team meetings, discussions of individual cases or other means.

**Example questions to discuss and think about.**

- Do we have regular burn care team meetings?
- How often?
- Who participates in these meetings?
- Which team members participate in the daily round?
- Are meetings held to discuss specific patient cases?
- How else does the team communicate, share information or make decisions about patient care?

**Maximum Scoring Scale**

1 Point

**Score 0**
Limited or no regular communication between team members

**Score 0.5**
Semi-regular communication and decision making

**Score 1**
Regular communication and scheduled team meetings

**Note**: some sub sections do not suit 'scoring' (i.e Sustainability), but they are still extremely important for the team to discuss.

# Example:
# DAT Notetaker Guide

**Section 3.0 Burn Care Team**
**Sub-Section 3.3: Team Communications**

- **3.0 Burn Care Team**
- Burn MDT (3)
- Clinical Lead (1)
- Team Communications (1)
- Level of Burn Training (2)
- Access to other specialities (1)
- Overall staffing capacity (2)

**Example questions to discuss and think about.**

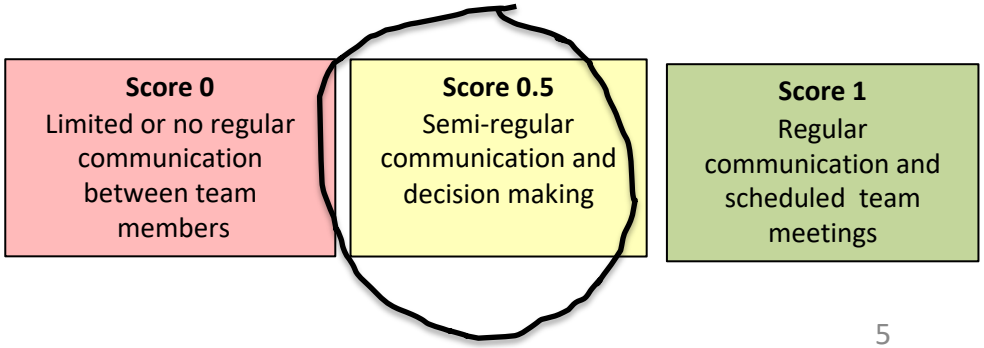
- We try to have meetings about once a month, but not scheduled.

- Members of the burn team who are on duty that day – depends who is on duty.

- The nurse.

- We don't have meetings to discuss specific patients, we are too busy.

- Some people use WhatsApp.



# Start DAT

Turn off ALL electronic equipment

Sit comfortably

Speak openly

- 1.0 Policies and Procedures
- **Referral (0)**
- Transfer (0)
- Burn ward/burn beds (3)
- Discharge planning and follow up (2)
- Burn management guidelines (2)
- Non survivable burns and palliative care (1)
- Operational and management issues (2)

**Definition:** the referral of the care of a patient **from** another service **to** the service being assessed.

**Primary Purpose:** to understand the national referral system, the service's place in it and relationship with other hospitals.

**What we want to understand.**

- Is there a national referral system in place.
- How do patients come to the service and where from (referring hospitals and geographical location).
- Practical issues faced by patients e.g. transport issues (ambulance, public/private transport); access issues i.e. distance or geography, or finance.
- What information is provided before the patient arrives; is there a standard document for referrals.
- Who decides if a patient is accepted, are there formal/informal criteria; are there patients you do no accept.
- What are typical reasons for referral i/e reconstructive surgery or access to intensive care.

**Example questions to discuss.**
**(Also add your own)**

- Which hospitals refer patients to our service?
- Why are patients referred?
- What challenges do patients face in reaching our service?
- Who makes the decision to accept referrals and how is this decision made?
- Do we have a formal protocol for referrals?
- How are referrals documented?

This section is important but there is no score attached.

- **1.0 Policies and Procedures**
- Referral (0)
- **Transfer (0)**
- Burn ward/burn beds (3)
- Discharge planning and follow up (2)
- Burn management guidelines (2)
- Non survivable burns and palliative care (1)
- Operational and management issues (2)

**Definition:** the transfer of the care of a patient **to** another service **from** the service being assessed.

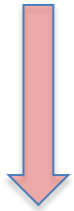
**Primary Purpose:** Discussion of transfer can be part of the discussion on referral as areas overlap. The discussion should discuss how the service fits in the wider healthcare system, if the service transfers patients to other services, what is the procedure, the reasons and who are the decision makers.

**What we want to understand.**

- If patients are transferred to other services, if so, which ones.
- Why patients are transferred i.e. To a specific aspect of care such as ICU or physiotherapy.
- How they are transferred (practical modes) – ambulance, public or private transport?
- How they are transferred in terms of process – if through a formal protocol or not?

**Example questions to discuss.**
**(Also add your own)**

- Why are patients typically transferred?
- How are patients transferred?
- Where are they transferred to?
- Do we have a formal protocol for transfers?
- How are transfers documented?



This section is important but there is no score attached.

**1.0 Policies and Procedures**

Referral (0)

Transfer (0)

**Burn ward/burn beds (3)**

Discharge planning and follow up (2)

Burn management guidelines (2)

Non survivable burns and palliative care (1)

Operational and management issues (2)

**Definition:** the burn unit is a distinct hospital unit specializing in the treatment of burns. A burn unit is a physically separate ward for the treatment of burns. Burn beds are the number of beds specifically reserved for burn patients.

**Primary Purpose:** to understand if patients are treated in a specialized unit, or ward, for burns, the overall inpatient bed capacity, the frequency and extent to which it is over capacity and the effect of capacity issues.

**What we want to understand.**

- Where patients are treated and what facilities are available.
- How many beds the service has and is there enough capacity and space.
- What other space is available ie for dressings, physiotherapy and play etc.
- What is the effect of seasonal variations in patient numbers

**Example questions to discuss. (Also add your own)**

- Is there a specific burn unit, ward or area for burn patients? Where is it?
- How many beds are there specifically for burn patients?
- Do we have enough burn beds for burns, relative for the number of patients?
- How often are we over capacity? (Rarely, Often, Never?).
- To what degree are we over-capacity? (Minor, Moderate, Severely?).
- What other spaces are there for burn care?(dressing room, physio area?)
- What effects do these issues have on delivery of care?

**Maximum Scoring Scale 3 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 | 3.0 |
|---|---|---|---|---|---|
| No burn beds, burn ward or separate area | No burn beds but steps to address this. | Severe deficiencies in beds/spaces | Significant deficiencies in bed space | Minor deficiencies in bed space | Sufficient burn beds and ward space all year |

**1.0 Policies and Procedures**

- Referral (0)
- Transfer (0)
- Burn ward/burn beds (3)
- **Discharge planning and follow up (2)**
- Burn management guidelines (2)
- Non survivable burns and palliative care (1)
- Operational and management issues (2)

**Primary Purpose:** How does the service plan for patients discharge, how are they followed up after discharge, what does the team understand as discharge planning and follow up after discharge. Think what is good discharge planning and follow up – what are the team's strengths and what works well.

**What we want to understand.**

- Is there a formal discharge planning service.
- Is there formal follow up procedure.
- Are these followed?
- How much are discharges decided by patient or clinical decision.
- What factors affect discharge (ie socioeconomic?).
- Who is in charge of discharge and follow up.
- What are the mechanism for follow up.
- What % of patients receive follow up care.
- What are the main barriers to effective follow up.

**Example questions to discuss.**
**(Also add your own)**

- Do we use formal discharge planning process?
- Is it followed?
- Is there a formal policy for patients post discharge? Is it followed?
- What % of patients needing follow up, receive it?
- Does the service hold out patient clinics or other services?
- How do patients with wounds get their dressings done? Will they see the burn team post discharge?
- Are there other places you can refer patients to for OPD care?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| No follow up process | No process but steps are in place | Informal process followed | Formal process, sometimes followed | Formal process, regularly followed |

**Definition:** Written guidelines that recommend how healthcare professionals should care for people with burn injuries.

**Primary Purpose:** to explore the team's understanding of what constitutes guidelines and protocols for clinical management.

**What we want to understand.**

- Which guidelines/protocols for clinical management are used.
Are they formal, written protocols, if not, how are informal guidelines used.
- Are these followed, how regularly and by how many staff.

**Example questions to discuss. (Also add your own)**

- Do we use formal guidelines or protocols for the management of burn patients?
- If yes, which guidelines?
- Are they followed - rarely, often, frequently? If not, why?
- Share and discuss an example guideline
- Introduce Interburns action checklists.

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| No burn management guidelines | No guidelines but steps in place | Informal guidelines followed | Informal guidelines in place | Formal guidelines implemented and followed |

**Definition**: an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening injury.

**Primary Purpose:** To explore the team's understanding of palliative care and non-survivable burns. It is a sensitive issue that needs to be handled with care.

**What we want to understand.**

- What does the team understand as non-survivable burns.

What is the understanding about palliative care and what is palliative care in the service.

Who makes the decision that care should be palliative, how is that decision made.

How is the decision communicated to the family.

**Example questions to discuss. (Also add your own)**

- Is there a formal policy on non-survivable burns and palliative care? Is it adhered to, if not is there a formal protocol?
- - How do we decide if a burn is survivable or not, who makes the decision?
- How do we talk to patients and their families about these issues?

**Maximum Scoring Scale**
**1 point**

| 0 | 0.5 | 1.0 |
|---|---|---|
| No specific palliative care strategies | Informal palliative care strategies | Formal strategies regularly followed |

1.0 Policies and Procedures
Referral (0)
Transfer (0)
Burn ward/burn beds (3)
Discharge planning and follow up (2)
Burn management guidelines (2)
Non survivable burns and palliative care (1)
**Operational and management issues (2)**

**Definition**: examples are - budget issues, authority over recruitment, retention and training of clinical and support staff, effect of organizational or government policies. Any non clinical issues.

**Primary Purpose:** An open discussion to find out if the service is affected by operational or management issues that impact the delivery of care.

**What we want to understand.**

- If there are any non clinical management and operational issues that affect service delivery and patient treatment in this service.

**Example questions to discuss.**
**(Also add your own)**

- Are there any operational or management issues that affect the delivery of our service?
- Is the hospital management supportive of our burn service?
- Are there issues around staff rotation, for instance to get training or moving on?
- Does burn care regularly fall at the bottom of the list for resoufrces?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| Severe operational and management issues affecting delivery | Severe issues but steps in place to address this | Significant operational and management issues affecting delivery | Significant issues but steps in place to address this | Staffing level sufficient for caseload |

**2.0 Burn service activities**

**Prevention (4)**

Training to other services (3)

Research(3)

Sustainability of key activities(0)

**Definition**: Primary burn prevention prevents burn injuries from happening and reduces the incidence of burns. This discussion should be wide-ranging to explore the team's understanding of prevention, rather than a narrow definition of the term.

**Primary Purpose:** An open discussion to explore the team's understanding of primary burn prevention, and if the service is involved in any activities to stop burns from happening.

**What we want to understand.**

- Is anyone engaged in primary prevention activities
- How often do these activities take place.
- Are they part of a formal or standardized programme or part of a local, national or international plan.
- Where are activities delivered (hospital or community) through which mechanisms or forms of media.

Examples of mechanisms: radio, TV poster, talks, education to patients; school or community posters

**Example questions to discuss. (Also add your own)**

- Are we involved in any burn prevention activities? If yes, who and which mechanisms or media are involved.
How regularly do these take place?
Are they part of a standardized programme?
If this is a national referral centre, does it have a national planning role?

**Maximum Scoring Scale**
**4 points**

| 0 | 0.5 | 1.0 | 2.0 | 3.0 | 4.0 |
|---|---|---|---|---|---|
| No prevention activities | No activities but steps are in place | Semi regular, informal activities | Semi regular formal, or regular informal activities | Regular formal prevention activities | Regular formal activities to a standard programme |

2.0 Burn service activities
Prevention (4)
Training to other services (3)
Research(3)
Sustainability of key activities(0)

**Definition:** A wide ranging exploration of any and all forms of training, or teaching different team members have been involved in, including informal and 'on the job' training. Interburns *Operational Standards* recommend training from higher levels to lower-level services.

**Primary Purpose:** to understand if the service trains other staff at other health facilities e.g hospitals/burn units; what are the links between hospitals, NGOs and others.

**What we want to understand.**

- Does the team provide training to other services.
- How regularly and frequently.
- Are they part of a formal, standardised programme or part of a national or international plan?
- Where and which services.

**Example questions to discuss. (Also add your own)**

- Do we deliver burn training to other facilities?
- What training programme?
- Which other services or audiences is it delivered to?
- Who delivers it
- How regularly is it conducted?
- *Examine confidence levels on a scale in doing training/prevention*.

**Maximum Scoring Scale**
**3 points**

| 0 | 0.5 | 1.0 | 2.0 | 3.0 |
|---|---|---|---|---|
| No training activities | No training activities but steps are in place | Semi regular, informal training | Semi regular formal, or regular informal training activities | Regular formal activities to a standard programme |

2.0 Burn service activities
Prevention (4)
Training to other services (3)
**Research(3)**
Sustainability of key activities(0)

**Definition:** This should be a wide-ranging discussion exploring the team's understanding of research including small scale studies up to formal research trials.

**Primary Purpose:** to explore the team's understanding of research and the extent to which the service is involved in research activities.

**What we want to understand.**

- How much are people involved in research activities and how regularly.
- Are they individual efforts, carried out collectively, or part of a national or international plan.
- Who is undertaking research.
- Who is funding it and how sustainable is the funding resource. Has research been published, or included in formal reporting.

**Example questions to discuss.**
**(Also add your own)**

- Do you understand the term, 'research'?
- Is anyone involved in research activities?
- What research have staff undertaken?
- Who?
- Who funded it?
- Has anyone published any research?

**Maximum Scoring Scale**
**3 points**

| 0 | 0.5 | 1.0 | 2.0 | 3.0 |
|---|---|---|---|---|
| No research activities | No research activities but steps are in place | Limited research activities by individual staff | Regular research by staff but lack of coordination/ funding | Regular research by staff with high level of coordination/ funding |

**2.0 Burn service activities**

Prevention (4)

Training to other services (3)

Research(3)

**Sustainability of key activities(0)**

**Primary Purpose:** to explore the level of support from hospital management and other sources for prevention, training and research activities in terms of funding, staff time and resources.

**What we want to understand.**
- To what extent are prevention, training and research activities sustainable at the service.

**Example questions to discuss.**
**(Also add your own)**

- does hospital management support prevention, training and research activities in terms of funding, staff, time and resources?
- Do we receive funding from external sources for these activities e.g. NGOs or private donations?
- How long is the funding in place for?

**Maximum Scoring Scale**
**0 points**

**3.0 Burn care team**

**Definition**: the MDT involves health care professionals from different disciplines, working together to deliver comprehensive and effective patient care.

**Burn multi disciplinary team (3)**

- Clinical lead (1)
- Team communication (1)
- Level of burn training (2)
- Access to other specialities (1)
- Overall staffing capacity (2)

**Core roles:** Medical and Nursing
**Ancillary support**: Physiotherapist, Occupational Therapist, Dietician, Psychosocial (either in team or external).

**Primary Purpose:** who is in the burn care team, which disciplines, and what levels of training and experience do they have. Are there enough staff in the unit, or is there access to other departments or externally.

**What we want to understand.**

- If there is a coherent burn team at the service
- What are the strengths and weaknesses of the current team, are there any gaps in key disciplines.
- Are these roles filled in other ways i.e. other staff, or external services.

**Example questions to discuss. (Also add your own)**

- Do we have a specific team to care for burn patients? Who is in it?
- What are strengths/ weaknesses of the team?
- Do we have a dedicated burn physio. Do we have access to one?
- Do we have access to a dietitian or nutritionist?
- Do we have access to a psychologist or psychosocial specialist?
- Are other staff filling these roles?

| 0 | 0.5 | 1.0 | 1.5 | 2.0 | 2.5 | 3.0 |
|---|---|---|---|---|---|---|
| No regular burn MDT | Key medical/nursing staff but low in numbers or training | Key medical/nursing staff but some deficiencies | Key medical/nursing staff but lack ancillary support | Key medical/nursing plus some ancillary support | Key medical/nursing plus enough ancillary support | Complete MDT including all disciplines |

**Definition:** Clinical lead is the head of the burn service and the one who has responsibility in the event of failure or error.

**Primary Purpose:** a clear question to confirm who the clinical lead for the burn service is and what their training or experience level in burn care is.

**Example questions to discuss.**
**(Also add your own)**

- Do we have a named clinical lead for our service?
- Who are they and what level of training and experience do they have?

**Maximum Scoring Scale**
**1 points**

| 0 | 0.5 | 1.0 |
|---|---|---|
| No clinical lead or clinical lead lacks burn experience or training | Clinical lead with limited training experience | Clinical lead with burn training and experience in burn care |

**3.0 Burn care team**

- Burn multi disciplinary team (3)
- Clinical lead (1)
- **Team communication (1)**
- Level of burn training (2)
- Access to other specialities (1)
- Overall staffing capacity (2)

**Primary Purpose:** a discussion of how the staff team communicates, shares information and makes decisions about patient care, whether through a regular team meeting, discussions of individual cases or other means.

**What do we want to understand:**

- How does the burn care team meet, communicate and make decisions about patient care.

**Example questions to discuss.**
**(Also add your own)**

- Do we have a regular burn care team meeting?
- How often?
- Who takes part?
- Are meetings held to discuss specific patients?
- How else does the team communicate and share information about patient care?

**Maximum Scoring Scale**
**1 points**

| **0** | **0.5** | **1.0** |
|---|---|---|
| Limited or no regular communication between team members | Semi regular communication and decision-making | Regular communication including regular team meeting |

**3.0 Burn care team**

- Burn multi disciplinary team (3)
- Clinical lead (1)
- Team communication (1)
- **Level of burn training (2)**
- Access to other specialities (1)
- Overall staffing capacity (2)

**Primary Purpose:** a discussion about whether staff team have received any burns training, including formal or 'on the job' training; to understand the team's understanding of continuing professional development (CPD).

**What do we want to understand:**

- What level of training and experience in burn care does the team have?
- Which training programmes?
- How useful has this been on daily practice?
- How much do team members share and disseminate training after a training programme?

**Example questions to discuss.**
**(Also add your own)**

- Have any of our staff received burns training?
- Who has received it?
- Which training programmes?
- How useful has the training been in improving daily practice?

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1.0** | **1.5** | **2.0** |
|---|---|---|---|---|
| No staff with burns training | Less than 50% staff with burns training | 50%+ key staff with burns training | 75%+ key staff with burn training | 90%+ key and senior staff with burns training |

3.0 Burn care team
Burn multi disciplinary team (3)
Clinical lead (1)
Team communication (1)
Level of burn training (2)
**Access to other specialities (1)**
Overall staffing capacity (2)

**Definition**: See Interburns *Operational Standards for Burn Care* for more information on team specialities.

**Primary Purpose:** to establish if the service has access to key specialities (stated in Interburns *Operational Standards for Burn Services*).

**What do we want to understand:**
- What access does the service have to other key specialities.

**Example questions to discuss.**
**(Also add your own)**

- Do we have access to other specialities such as: anaesthetist, renal, cardiac, general medical, paediatric, plastic or general surgeon?

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1** |
|---|---|---|
| Lack access to the majority of key specialities | Lack access to some key specialities | Access to all key specialities |

**3.0 Burn care team**

- Burn multi disciplinary team (3)
- Clinical lead (1)
- Team communication (1)
- Level of burn training (2)
- Access to other specialities (1)
- **Overall staffing capacity (2)**

**Definition**: capacity should be integrated into the wider discussion about the team, its training and experience.

**Primary Purpose:** to establish the overall staffing and team capacity of the service and the service's patient caseload relative to that capacity.

**What do we want to understand:**

- The extent to which the service has sufficient staff to manage all patients effectively.
- What the systemic pressures are on the current team and how severe those are.

**Example questions to discuss.**
**(Also add your own)**

- Do we have enough staff to manage our services effectively?
- If not, where are the gaps?
- How severe are systemic pressures (can the team characterize this e.g. minor, moderate, severe).

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2 |
|---|---|---|---|---|
| Severe deficiencies in staffing compared to patient case load (impact on care is severe) | Significant deficiencies in staffing compared to caseload (impact on care is significant) | Moderate deficiencies in staffing (moderate impact on care) | Minor deficiencies in staffing (minor impact on care) | Staffing levels sufficient for caseload (no impact on care) |

- 4.0 Surgery
- **Emergency surgery (2)**
- Early excision and skin grafting (4)
- Burn reconstructive surgery (2)
- Surgical capacity (2)

**Definition**: Emergency Care is medical or health treatment provided to an injured person for a sudden onset of a medical condition where failure to give immediate care would result in the patient's deterioration.

**Primary Purpose:** a discussion of what kinds of emergency surgical procedures the service provides and how confident the team is in delivering them.

**What do we want to understand:**

- The extent to which key emergency surgical procedures are being carried out by the team, at the right time in the right place by the right personnel.
- Examples of what we call emergency surgery: Escharotomy, Fasciotomy, Tracheostomy, venous access, septic patient that needs urgent debridement.

**Example questions to discuss.**
**(Also add your own)**

- Imagine you need to take a patient to surgery to perform an emergency surgical procedure – is this performed in a timely manner, for what proportion of patients?
- Which emergency surgical procedures does your service regularly perform on burn patients?
- Who does it, are they confident and when do they perform it?
- What proportion of patients requiring emergency surgery receive it in good time (approximate estimate).

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| Not delivering emergency surgery | Not delivering emergency surgery but steps are in place | Delivering emergency surgery to a limited degree | Delivering emergency surgery to a majority of patients requiring it | Delivering emergency surgery to all patients requiring it |

- 4.0 Surgery
- Emergency surgery (2)
- **Early excision and skin grafting (4)**
- Burn reconstructive surgery (2)
- Surgical capacity (2)

**Definition**: **Early excision** is operative excision within 7 days post burn injury. **Skin grafting**: where skin is used to cover an area where the patient's skin has been lost due to a burn, typically from one part of the body to another.

**Primary Purpose:** a discussion of the delivery of early surgical excision and skin grafting for burn patients.

**What do we want to understand:**

- How and when patients are skin grafted
- When is it performed
- Who makes decisions about the need for excision and grafting
- How is the decision made
- Is the surgery performed in time, and for what % of patients.
- What barriers exist to grafting all patients who need it
- How confident is the team in post-operative care.

**Example questions to discuss.**
**(Also add your own)**

- Does our service regularly perform early burn wound excision? Who does it and are they confident in performing early excision?
- When do we perform it?
- What proportion of patients needing early excision, receive surgery in a timely manner?
- Do we regularly perform skin grafting?
- Who does it and are they confident in performing it?
- What proportion of patients needing skin grafting receive it in good time?
- What size (TBSA) burn are the team confident in grafting in one operation?
- How confident are we as a team in post operative care?

| 0 | 0.5 | 1.0 | 2.0 | 3.0 | 4.0 |
|---|---|---|---|---|---|
| Not delivering excision and skin grafting | Not delivering excision and skin grafting; steps in place | Delivering excision and skin grafting to a limited degree | Delivering excision and skin grafting to some patients | Delivering skin grafting to the majority of patients | Delivering excision and grafting to all patients requiring it |

4.0 Surgery

Emergency surgery (2)

Early excision and skin grafting (4)

**Burn reconstructive surgery (2)**

Surgical capacity (2)

**Definition**: Burn reconstructive surgery is only expected at *Advanced- level burn services* in the Operational Standards.

**Primary Purpose:** a discussion of the delivery of reconstructive surgery to burn patients.

**What do we want to understand:**

- What the decision-making process for burn reconstructive surgery is.
- Where burn recon. patients at this service come from.
- What types of recon. surgery are offered by this service.
- Are they admitted to burn beds or other parts of the hospital.

**Example questions to discuss.**
**(Also add your own)**

- Does our service regularly perform reconstructive surgery on burn patients?
- What types of reconstructive surgery are offered?
- Who does it?
- What level of training do they have in reconstructive surgery?
- When do they perform it?
- Where is it performed?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| Not delivering reconstructive surgery | Not delivering recon surgery but steps in place | Delivering recon surgery to a limited degree | Delivering recon surgery to the majority of patients | Delivering recon surgery to all patients requiring it |

4.0 Surgery

Emergency surgery (2)

Early excision and skin grafting (4)

Burn reconstructive surgery (2)

**Surgical capacity (2)**

**Definition:** surgical capacity should be integrated into the wider discussion about the team, its training and experience.

**Primary Purpose:** to discuss the specific capacity to deliver surgical care.

**What do we want to understand:**

- Does the service possess sufficient surgical staff, anaesthetic staff and operating theatre capacity for effective surgical management of burn patients.

**Example questions to discuss.**
**(Also add your own)**

- Do we have enough surgical staff, anaeshetic staff and other operating theatre staff to manage the service effectively?
- Is the delivery of surgical care affected by a lack of operating theatre availability, surgical kit or other resources?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| Severe deficiencies In surgical / anaesthetic staffing | Significant deficiencies in surgical / anaesthetic staffing | Moderate deficiencies in surgical / anaesthetic staffing | Minor deficiencies in surgical / anaesthetic staffing | Sufficient surgical / anaesthetic staffing |

**5.0 Nursing**

**Infection control (3)**

Paediatric care(2)

Dressings and wound care (3)

Nursing capacity (2)

**Primary Purpose:** a broad discussion of the team's understanding of infection control, and how they manage infection; what kind of infection protocols are in place, are they followed and what are the barriers to improving infection control.

**What do we want to understand:**

- What measures does the service have in place for infection control.
- What do the team think are the main causes of infection.
- What do the team think are the main barriers to improving infection control.

**Example questions to discuss.**
**(Also add your own)**

- What measures do we have in place for infection control?
- What do we think are the main causes of infection in our service?
- What do we think are the main barriers to improving infection control?
- Are we confident in recognizing an infected burn wound?

**Other points for discussion**:

- ❖ Patient, staff and visitor hygiene and control.
- ❖ Handwashing and cleanliness of space.
- ❖ Management of infected cases ie separate space?
- ❖ Use of gloves, aprons, masks.
- ❖ Access to water, and quality of water.
- ❖ Limiting use of antibiotics.

**Maximum Scoring Scale**
**3 points**

| 0 | 0.5 | 1.0 | 2.0 | 3.0 |
|---|---|---|---|---|
| Little or no effective infection control | Significant deficiencies in infection control | Moderate deficiencies in infection control | Minor deficiencies in infection control | No significant deficiencies in infection control |

**Primary Purpose:** to examine the team's awareness of the need to treat child burn patients differently and the extent to which steps are taken to implement this. Adjust this discussion in services that only treat adult patients.

**What do we want to understand:**

- Whether child's patients receive treatment differently from adult patients.
- Whether paediatric patients are segregated from adult patients.
- If there is a specific space and equipment for children to play.
- If any wards or spaces are child-friendly environments.
- To what extent are parents involved in aspects of care.
- If there are any staff trained specifically in paediatric care.

**Definition:** Ask the team who they define as a 'paediatric patient' according to local parameters i.e under 15?

**Example questions to discuss.**
**(Also add your own)**

- How do we treat children with burns differently form adult patients? Discuss specific examples.
- Where are paediatric patients treated?
- Do we have a specific place for children to play?
- To what extent do we involve parents in the care of patients?
- Have we received any training specifically in paediatric burn care?

**Maximum Scoring Scale**
**2 points**

| 0 | 1.0 | 3.0 |
|---|---|---|
| Staff not aware of need and not trained in specific paediatric treatment | Some staff aware of need and trained | All staff aware of an trained in paediatric treatment |

**5.0 Nursing**

Infection control (3)

Paediatric care(2)

**Dressings and wound care** (3)

Nursing capacity (2)

**Primary Purpose:** a discussion of how the team carries out wound care and dressing changes, the resources for these and barriers to improving practice.

**What do we want to understand:**

- How confident is the team in caring for burn wounds.
- How confident is the team in changing dressings.
- How often are these carried out and by who.
- How is pain managed during dressing changes
- Are these affected by lack of resources?

**Example questions to discuss.**
**(Also add your own)**

- Can we carry out regular dressing changes as required? Who does these, including post operatively. How often do we change dressings?
- How good is the team at caring for wounds and carrying out dressing changes?
- How do we monitor wounds, who looks at it and how often?
- What are the barriers to performing dressing changes?
- How do we manage pain during dressing changes?

**Maximum Scoring Scale**
**3 points**

| 0 | 0.5 | 1.0 | 2.0 | 3.0 |
|---|---|---|---|---|
| Severe problems in dressing changes to a good standard | Significant deficiencies in dressings and wound care | Moderate deficiencies in dressings and wound care | Minor deficiencies in dressings and wound care | No deficiencies in dressings and wound care |

**5.0 Nursing**

Infection control (3)

Paediatric care(2)

Dressings and wound care (3)

**Nursing capacity** (2)

**Primary Purpose:** a wide discussion about the nursing team, their experience and training levels. First, discuss the strengths and opportunities before looking at gaps and weaknesses.

**What do we want to understand:**

- Does the service have sufficient nursing staff for the effective management of burn patients.
- How does the team share learning, best practice and external training with colleagues.
- The impact of training on the confidence and skills of the nursing team.
- What are the barriers to improving nursing care in the service.

**Example questions to discuss.**
**(Also add your own)**

- Is there sufficient nursing staff for effective management of burn patients?
- Who leads the nursing team; what is their experience and training?
- What training do other members of the team have?
- Did they find it helpful? (examples of where they have changed practice)
- How do nursing staff share best practice and external training or learning?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2 |
|---|---|---|---|---|
| Severe deficiencies in nursing staffing | Significant deficiencies in nursing staffing | Moderate deficiencies in nursing staffing | Minor deficiencies in nursing staffing | Sufficient nursing staffing |

**6.0 Treatment**

- **Pain management (3)**
- Emergency care(2)
- Critical care (2)
- Fluid resuscitation (1)
- Nutrition (2)

**Definition**: Pain management is the process of providing medical care that alleviates or reduces pain.

**Primary Purpose:** a discussion about the team's understanding of pain management, looking at pharmacological and non-pharmacological approaches. Examples of non-pharma approaches: counselling, distraction, therapy, play.

**What do we want to understand:**

- What strategies does the team use for pain control, pharmacological and non-pharmacological.
- When are they used.
- Does the team have strong enough pain control?
- Who pays for analgesia.
- Are pain levels assessed, if so how and by whom?

**Example questions to discuss.**
**(Also add your own)**

- Do we think our patients have good pain control?
- What methods of pain control do we use?
- How often do we provide pain control.
- Who pays for it?
- Are pain meds given before painful procedures such as dressings, if so, which meds?
- Do we assess pain, how?

**Maximum Scoring Scale**
**3 points**

| 0 | 1 | 2 | 3 |
|---|---|---|---|
| Little or no effective pain control | Limited access to pain control | Moderate access to pain control | Good access to pain control |

- 6.0 Treatment
- Pain management (3)
- **Emergency care(2)**
- Critical care (2)
- Fluid resuscitation (1)
- Nutrition (2)

Definition: Medical or health treatment given to an injured person for a sudden onset of a medical condition where failure to give immediate care would result in their medical condition.

**Primary Purpose:** a discussion of where burn patients receive emergency care at the hospital and how patients are managed, including critically ill patients.

**What do we want to understand:**

- Where admissions are received and who they are managed by.
- How are they managed.
- How critical patients are managed

**Example questions to discuss.**
**(Also add your own)**

- Where are emergency admissions received?
- How are they managed?
- How does the team manage a patient arriving in a critical condition?

**Example discussion points for management**:

- ABCDE by appropriate doctor,
- timely provision of oxygen,
- intubation capability
- Availability of drugs,
- Vital sign monitoring,
- Ventilation.

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1 | 1.5 | 2 |
|---|---|---|---|---|
| Unable to deliver effective emergency care | Not delivering but steps are in place to address this | Delivering emergency care to a limited degree | Delivering to the majority of patients needing it | Delivering emergency care to all patients needing it |

**6.0 Treatment**

- Pain management (3)
- Emergency care(2)
- **Critical care** (2)
- Fluid resuscitation (1)
- Nutrition (2)

**Definition**: the specialized care of patients whose conditions are life-threatening and requiring comprehensive care and constant monitoring.

**Primary Purpose:** a discussion of how the team understands critical care, and the extent to which critical and high dependency care is available at the hospital, either in the burn unit of the general ICU

**What do we want to understand:**

- The team's understanding of 'critical care'
- The facilities available for critical or high dependency care e.g. availability of ICU of HDU.
- If the service has adequate cover by anaesthetists.
- How confident the team if in treating critically ill patients

**Example questions to discuss.**
**(Also add your own)**

- What do we understand as critical care?
- How do we treat and monitor critically ill patients?
- Where are they treated and by whom?
- Are they routinely ventilated?
- What are the key barriers to improving critical care?

**Maximum Scoring Scale**
**2 points**

| **0** | **0.5** | **1** | **1.5** | **2** |
|---|---|---|---|---|
| Unable to deliver effective critical care | Not delivering but steps are in place to address | Delivering critical care to a limited degree | Delivering to the majority of patients needing it | Delivering critical care to all patients needing it |

**6.0 Treatment**

- Pain management (3)
- Emergency care(2)
- Critical care (2)
- **Fluid resuscitation** (1)
- Nutrition (2)

**Primary Purpose:** a discussion of how the team monitors and manages fluid resuscitation in burn patients for large burns.

**What do we want to understand:**

- Which protocol is used for fluid resuscitation.
- How is fluid balance monitored.
- What are the problems and barriers to effect fluid resuscitation of adults and children (including supplies and training).

**Example questions to discuss.**
**(Also add your own)**

- Which protocols do we use for fluid resuscitation?
- How do we monitor fluid balance?
- Which solutions are used for fluid resuscitation?
- How could we improve fluid resuscitation in our service?
- What are the main barriers to improving fluid resuscitation?

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1** |
|---|---|---|
| Very few staff confident in assessing/ calculating fluid resuscitation | Some staff confident in assessing fluid resuscitation | All staff confident in assessing fluid resuscitation |

**6.0 Treatment**

- Pain management (3)
- Emergency care(2)
- Critical care (2)
- Fluid resuscitation (1)
- **Nutrition** (2)

**Primary Purpose:** to discuss the understanding of nutritional needs of burn patients, what kind of food and support patients receive, how it is paid for and if a trained nutritionist or dietician is available (in the unit or hospital).

**What do we want to understand:**

- How are nutritional needs managed.
- Is there access to a dietician in the unit or hospital (how many days/hours).
- What food is provided, is it a high protein diet (HPD), and what is the quality.
- How is nutrition monitored.

**Example questions to discuss.**
**(Also add your own)**

- Does the team provide nutritional support for burn patients?
- What kind of food do we provide, is there access to a high protein diet?
- Who pays for it? If patients pay, what proportion of patients cannot pay for it?
- Do we have access to a trained nutritionist or dietician?
- Is the patient's weight monitored?
- Is NG feeding used?
- Are nutritional supplements used?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1 | 1.5 | 2 |
|---|---|---|---|---|
| Unable to deliver effective nutrition to burn patients | Not delivering but steps are in place | Delivering nutrition to a limited degree | Delivering to a majority of patients needing it | Delivering nutrition to all patients needing it |

**7.0 Rehabilitation**

- **Positioning (2)**
- Mobilisation (2)
- Splinting (2)
- Scar management (1)
- Therapy follow up (1)
- Rehabilitation capacity (2)
- Access to therapy
- Contracture

**Primary Purpose: a** discussion of how staff use positioning to prevent contractures and manage oedema, how patient compliance is managed, what equipment is used and barriers to implementing positioning.

**What do we want to understand:**

- What proportion of patients are positioned in anti contracture positions.
- Which staff are responsible, do they involve the patient and family.
- Is equipment used.
- What are the main barriers to correct positioning.

**Example questions to discuss.**
**(Also add your own)**

- Do our staff know the correct way to position patients? Who does it, do they manage oedema?
- What % are positioned in anti contracture positions, what % are not?
- Who makes sure patients comply? (therapist, nurse, families?)
- Is equipment used for positioning?
- Do staff know about anti contracture positions?
- What are the main barriers?

**Maximum Scoring Scale**
**2 points**

| **0** | **0.5** | **1** | **1.5** | **2** |
|---|---|---|---|---|
| Unable to deliver effective anti contracture positioning | Not delivering but steps are in place | Delivering anti contracture positioning to a limited degree | Delivering positioning to a majority of patients | Delivering positioning to all patients needing it |

**7.0 Rehabilitation**

- Positioning (2)
- **Mobilisation (2)**
- Splinting (2)
- Scar management (1)
- Therapy follow up (1)
- Rehabilitation capacity (2)
- Access to therapy
- Contracture

**Primary Purpose: a** discussion of how effectively patients are mobilised and who is involved, what equipment is used and what are the main barriers.

**What do we want to understand:**

- What proportion of patients are mobilised.
- Who is responsible for this, do they involve the family to ensure compliance.
- Is any equipment used?
- What are the main barriers.

**Example questions to discuss.**
**(Also add your own)**

- Are we able to mobilise patients regularly?
- Who does it?
- How often?
- Are all patients who are able to mobilise, doing so every day?
- What % are not?
- Who ensures compliance?
- Does pain limit mobilisation?
- What are the main barriers to achieving good mobilisation?

**Maximum Scoring Scale**
**2 points**

| **0** | **0.5** | **1** | **1.5** | **2** |
|---|---|---|---|---|
| Unable to deliver effective mobilisation to any patient | Not delivering effective mobilisation but steps are in place | Delivering effective mobilisation to a limited degree | Delivering effective to a majority of patients | Delivering to all patients needing it |

**7.0 Rehabilitation**

- Positioning (2)
- Mobilisation (2)
- **Splinting** (2)
- Scar management (1)
- Therapy follow up (1)
- Rehabilitation capacity (2)
- Access to therapy
- Contracture

**Primary Purpose: a** discussion of the use of splinting to prevent deformity, looking at equipment and materials available, staff involved and barriers.

**What do we want to understand:**

- What proportion of patients who need splints receive them.
- Which staff are responsible and do they involve the patient and family.
- What equipment and splinting materials are available.
- What are the main barriers to splinting.

**Example questions to discuss.**
**(Also add your own)**

- Do we splint patients?
- Who does the splinting, where and when?
- Which materials are used?
- Can we splint all patients who need them? What % are not?
- Who pays for split materials?
- Are any patients not splinted due to costs?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1 | 1.5 | 2 |
|---|---|---|---|---|
| Unable to deliver effective splinting to any patients | Not delivering effective splinting but steps are in place | Delivering effective splinting to a limited degree | Delivering effective splinting to a majority of patients | Delivering to all patients needing it |

**7.0 Rehabilitation**

- Positioning (2)
- Mobilisation (2)
- Splinting (2)
- **Scar management** (1)
- Therapy follow up (1)
- Rehabilitation capacity (2)
- Access to therapy
- Contractures

**Primary Purpose:** to understand if the team offers any scar management.

**What do we want to understand:**

- How the team understands scar management.
- Who provides it and what techniques they use.
- If it is available to inpatients, and/or post discharge.
- What materials are available for scar management and massage
- Who pays for them and is cost a barrier to treatment.

**Example questions to discuss.**
**(Also add your own)**

- What techniques of scar management do we use?
- Who provides scar management?
- Is there post discharge scar management?
- Does the patient have a say?
- What materials or consumables do we use e.g creams, silicon gels, pressure garments coconut oil, sun protection, other?

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1** |
|---|---|---|
| Not delivering effective scar management or a limited degree | Delivering effective scar management to a moderate degree | Delivering effective scar management to majority of patients |

**7.0 Rehabilitation**

- Positioning (2)
- Mobilisation (2)
- Splinting (2)
- Scar management (1)
- **Therapy follow up** (1)
- Rehabilitation capacity (2)
- Access to therapy
- Contractures

**Primary Purpose:** a discussion of post discharge follow up for patients, for therapy and rehabilitation.

**What do we want to understand:**

- If there is an effective system for effective follow up post discharge for therapy and rehabilitation.
- How is it made available (OPD clinics, or therapy in other services)
- What are the main barriers to improving follow up.

**Example questions to discuss.**
**(Also add your own)**

- Are there enough resources for therapists to see patients post discharge?
- Are therapists involved in OPD clinics, or arrange therapy nearer home?
- Is there a follow-up system?
- What do we think are the main barriers to achieving good follow up?

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1** |
|---|---|---|
| Not delivering effective therapy follow up or to a limited degree | Delivering effective therapy follow up to a moderate degree | Delivering effective therapy follow up to the majority of patients |

**7.0 Rehabilitation**

- Positioning (2)
- Mobilisation (2)
- Splinting (2)
- Scar management (1)
- Therapy follow up (1)
- **Rehabilitation capacity (2)**
- Access to Therapy
- Contracture

**Definition**: Restoring the patient's mobility and ability to return to their daily life post-injury

**Primary Purpose:** a broad discussion about the ability to deliver rehabilitation, access to physiotherapy and/or occupational therapy; who delivers it and their experience. Discuss strengths first, before looking at gaps and weaknesses.

**What do we want to understand:**

- If there are enough staff, equipment and facilities for effective rehabilitation in both inpatient and outpatient services.
- Is there access to a physio or occupational therapist and have they had specific training in burn care?
- What % of patients requiring physio, receive it in a timely manner.
- What are the challenges and barriers to improving rehabilitation and therapy.

**Example questions to discuss. (Also add your own)**

- Do we have access to physiotherapy or occupational therapy staff for rehabilitation of burn patients?
- How many hours or days are they available?
- Do we have the equipment and facilities we need for rehabilitation?
- Who is delivering rehabilitation to burn patients?
- Have they had specific training and what is their level of experience?
- What % of patients needing physiotherapy receive it in good time?
- What barriers are there to improving rehabilitation, physiotherapy and occupational therapy?

| 0 | 0.5 | 1 | 1.5 | 2 |
|---|---|---|---|---|
| Severe deficiencies in therapy staffing (severe impact | Significant deficiencies (significant impact) | Moderate deficiencies (moderate impact) | Minor deficiencies in therapy staff (minor impact | Sufficient therapy staffing (no impact on care) |

**Definition**: Restoring the patient's mobility and ability to return to their daily life post-injury

**Primary Purpose:** a discussion of how patients are referred for therapy and rehabilitation, how effective the process is and how the decision about therapy is made.

**What do we want to understand:**

- The process by which patients are referred for therapy.
- How timely and efficiently the process is.
- Who makes the decision on therapy treatment.

**Example questions to discuss.**
**(Also add your own)**

- How do we refer a patient for therapy?
- e.g through a therapist on a ward round, verbal instruction from a doctor, no referral necessary?
- Is referral timely and efficient?
- Is treatment decided by the therapist or doctors?

No score but the discussion is important.

7.0 Rehabilitation
Positioning (2)
Mobilisation (2)
Splinting (2)
Scar management (1)
Therapy follow up (1)
Rehabilitation capacity (2)
Access to therapy
**Contractures**

**Definition**: a contracture is the tightening of the skin after the 2nd or 3rd degree burn. When skin is burned, the surrounding skin begins to pull together, resulting in a contracture. It needs to be treated as soon as possible because the scar can result in restriction of movement around the injured area.

**Primary Purpose:** a discussion of the incidence of burn contractures in a burn service.

**What do we want to understand:**

- The proportion of patients that develop contractures.
- What are the main factors that cause contractures.
- What are the main barriers to reducing contractures.

**Example questions to discuss.**
**(Also add your own)**

- What % of patients develop contractures in the service?
- What do the team see as the main cause of contractures? e.g is there a lack of effective splinting, pain control, poor mobilization, positioning compliance, patient/family education?
- What do we think are the main barriers to reducing the rate of contractures?

No score but the discussion is important.

**8.0 Patient support**

- **Financial support (3)**
- Social work and legal support (2)
- Psychosocial support (3)
- Support for consumables (2)

**Primary Purpose:** a discussion of the financial support available for patients to help with the costs of treatment and other related costs.

**What do we want to understand:**

- Whether financial support is available.
- How significant it is and what it covers.
- What proportion of patients can access it.
- The extent to which cost is a barrier to care for patients.

**Example questions to discuss.**
**(Also add your own)**

- Is there any financial support available for burn patients?
- Where from?
- How much?
- Is it available for all patients?
- For which aspects of treatment?
- What costs do patients have to pay for, are there discounts or social support funds available?

**Maximum Scoring Scale**
**3 points**

| 0 | 0.5 | 1.0 | 2.0 | 3.0 |
|---|---|---|---|---|
| Service is not providing financial support | No financial support but steps in place | Service provides a limited degree of financial support | Providing significant financial support to some | Significant support to the majority of patients |

**8.0 Patient support**

- Financial support (3)
- **Social work and legal support (2)**
- Psychosocial support (3)
- Support for consumables (2)

**Primary Purpose:** a discussion of social work and legal support available.

**What do we want to understand:**

- If patients are able to access social work.
- If patients are able to access legal support.

**Example questions to discuss.**
**(Also add your own)**

- Is there access to a social worker?
- Do patients have access to social workers or social welfare support?
- Is there legal or advocacy support?
- Does the service offer specific support for patients who are victims of intentional burn injuries/violence?
- Is there support for patients to re integrate back into society after the burn injury?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| Little or no access to social work and/or legal support | Little or no access but steps in place | Limited access to social work and/or legal support | Majority able to access social work and/or legal support | Almost all able to access social support and/or legal work |

**8.0 Patient support**

Financial support (3)

Social work and legal support (2)

**Psychosocial support** (3)

Support for consumables (2)

**Definition**: Psychosocial care is care to address the psychological needs of burn patients and the social factors affecting them post injury. Ask the team to define their understanding of psychosocial care.

**Primary Purpose:** a discussion of psychosocial care and availability in the burn service.

**What do we want to understand:**

- How the team understands the concept of psychosocial care
- If psychosocial care is available and what the referral process is.
- Who is delivering this care and what is their level of training.
- How is this funded.
- Is support available post discharge.

**Example questions to discuss.**
**(Also add your own)**

- How do we manage the psychosocial needs of patients?
- Is there access to counselling or psychosocial support? How often, and how do patients access it.
- Is is delivered by non specialists e.g a nurse, or a therapist with skills/training in emotional or psychological support?
- What is the level of training of those who deliver it?
- What are the referral criteria, is it available to all or only those with specific problems?
- How is it funded?
- How are patient's needs identified?
- Is any support available post discharge – days/hours?
- Are there any peer support or survivor groups?

| 0 | 0.5 | 1.0 | 2.0 | 3.0 |
|---|---|---|---|---|
| Service is providing no psychosocial support | No psychosocial support but steps in place | Limited number of patients able to access | Majority able to access psychosocial support | Almost all able to access psychosocial support |

**8.0 Patient support**

- Financial support (3)
- Social work and legal support (2)
- Psychosocial support (3)
- **Support for consumables** (2)

**Definition**: Support for purchasing/supplying resources and consumables necessary for treating burn patients.

**Primary Purpose:** a discussion of support for consumables for burn patients.

**What do we want to understand:**

- The extent to which the team is supported in accessing resources and consumables for the effective treatment of burn patients.

**Example questions to discuss.**
**(Also add your own)**

- Are consumables available as and when needed?
- Are consumables free for patients, is this time-limited?
- Are there enough dressings, or do patients need to buy or provide their own?
- Are there limits on the available dressings per patient or by time?
- Do we feel supported in requests for supplies i.e. analgesia, dressings, food.

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| Severe lack of support for consumables (impact on care is severe) | Significant lack of support for consumables (impact is significant) | Moderate lack in support for consumables | Minor lack in support for consumables | Support for consumables enough for caseload. |

**9.0 Patient Outcomes and Data Management**

**Documentation (2)**

Data collection / Management(2)

QI/Audit(1)

Mortality/ morbidity data(1)

Patient Reported Outcome Measures (1)

Patient Reported Experience Measures (1)

Outcomes and data capacity (2)

**Primary Purpose:** a discussion to explore the documentation and record keeping system.

**What do we want to understand:**
- What types of records and notes the team keeps for burn patients.
- What system is used for storing them.
- Which team members are involved in writing and keeping records.

**Example questions to discuss.**
**(Also add your own)**

- What do we think is our team's ability to keep good, clear records?
- Are the medical notes clear and easy to read?
- Are they actually being used?
- What is the system (paper/digital), where are they stored?
- Which team members write the notes?
- Which documentation is available from nurses and therapists?
- Is past history of new admission clear?
- Are operation notes available and clear?
- Are drug and observation charts regularly completed and clear?

**Maximum Scoring Scale**
**2 points**

| **0** | **0.5** | **1.0** | **1.5** | **2.0** |
|---|---|---|---|---|
| No effective documentation and record keeping | Documentation and record keeping implemented b ut major gaps | Documentation and record keeping implemented but many gaps | Consistently strong with minor gaps | Strong with no gaps |

**9.0 Patient Outcomes and Data Management**

- Documentation (2)
- **Data collection / Management**(2)
- QI/Audit(1)
- Mortality/ morbidity data(1)
- Patient Reported Outcome Measures (1)
- Patient Reported Experience Measures (1)
- Outcomes and data capacity (2)

**Primary Purpose:** a discussion of the data collection and data management systems used.

**What do we want to understand:**

- What kind of burn patient data the service collects.
- How this data is managed and used.
- Who is responsible for managing it.
- If the team are aware of the WHO Global Burn Registry and if this could be a useful tool for staff.

**Example questions to discuss.**
**(Also add your own)**

- Do we collect any burn patient data?
- What data?
- Are burn patients differentiated in data collection?
- How is the data used?
- How is the data managed(paper/electronic system)?
- Who is responsible for managing it?
- Is it inpatient and outpatient data?
- Are team members aware of the WHO Global Burn Registry (GBR)?

**Maximum Scoring Scale**
**2 points**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| No effective data collection | Limited data collection but steps in place | Data collection implemented but major gaps | Consistent data collection with minor gaps | Strong data collection with no gaps |

**Definition:** Ask the team to define their understanding of QI. Audit in healthcare is used by health professionals to assess, evaluate and improve patient care in a systematic way. QI is about making healthcare safer, effective and patient centred, timely, efficient and equitable.

**Primary Purpose:** a discussion of the degree to which the service is aware of and implements QI and audit processes.

**What do we want to understand:**

- If the team is aware of the need for audit and quality improvement.
- To what extent are they implementing audit and QI processes.
- What are the barriers to the effective use of data for QI and audit.

**Example questions to discuss.**
**(Also add your own)**

- Do we use collected data for quality improvement or audit?
- Ask the team for a specific example of how this is used.
- What do we think are the main barriers to using data for quality improvement and audit?

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1.0** |
|---|---|---|
| No QI or audit activities | Limited or irregular QI and audit activities | Implementing regular QI and audit activities |

**Primary Purpose:** a discussion of the mortality and morbidity data collected by the service for burn patients.

**What do we want to understand:**

- If the service collects any mortality and morbidity data.
- If this data is used, and how.

**Example questions to discuss.**
**(Also add your own)**

- Do we collect any mortality or morbidity data?
- Is our team aware of the mortality rate?
- What is it?
- Do we record contracture rate, infection rate or other morbidity information?
- How do we use that data?

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1.0** |
|---|---|---|
| Not collecting mortality and morbidity data | Irregular or limited collection of M+ M data | Regular consistent collection of M + M data |

**Definition**: Patient-reported outcome measures (PROMs) are questionnaires measuring the *patients' views of their health status*.

**Primary Purpose:** a discussion of the patient outcome measures used by the service.

**What do we want to understand:**
- Does the service use patient outcome measures?
- Which ones?

**Example questions to discuss.**
**(Also add your own)**
- Do we use any patient outcome measures (clinical or non clinical?). Please share examples.

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1.0** |
|---|---|---|
| Not implementing any PROMs | Limited implementation of PROMs | Regular implementation of PROMs |

**Definition:** Patient-reported experience measures (PREMs) are questionnaires measuring the *patients' perceptions of their experience while receiving care.*

**Primary Purpose:** a discussion of the patient experience measures used by the service.

**What do we want to understand:**
- Does the service use patient experience measures?
- Which ones?

**Example questions to discuss.**
**(Also add your own)**
- Do we use any patient experience measures (clinical or non clinical?). Please share examples.

**Maximum Scoring Scale**
**1 point**

| **0** | **0.5** | **1.0** |
|---|---|---|
| Not implementing any PREMs | Limited implementation of PREMs | Regular implementation of PREMs |

- **9.0 Patient Outcomes and Data Management**
- Documentation (2)
- Data collection / Management(2)
- QI/Audit(1)
- Mortality/ morbidity data(1)
- Patient Reported Outcome Measures (1)
- Patient Reported Experience Measures (1)
- **Outcomes and data capacity (2)**

**Primary Purpose:** a discussion of the service's capacity to collect, manage and use data effectively for quality improvement and outcome measurement.

**What do we want to understand:**

- If the service has enough capacity for the collection and management of patient data and outcomes.

**Example questions to discuss.**
**(Also add your own)**

- Do we have enough capacity for the collection and management of patient data and outcomes? e.g
  - allocation of staff time
  - training
  - equipment
  - quality of record keeping. measures (clinical or non clinical?).

**Maximum Scoring Scale**
**2 point**

| 0 | 0.5 | 1.0 | 1.5 | 2.0 |
|---|---|---|---|---|
| Severe lack in data collection capacity (impact is severe) | Significant lack in capacity (impact is significant) any PREMs | Moderate lack in capacity (impact is moderate) | Minor lack in capacity (impact is minor) | No lack in data collection capacity (no impact) |

## Section 10 requires your collective judgement.
## The section should take around 5-10 minutes.

**Primary Purpose:** a review of the equipment and facilities checklist as defined in the Operational Standards. **What do we want to understand:**

- Which equipment and facilities does a service have access to.
- Where are the gaps in equipment and facilities affecting the delivery of service.

**Note: Section 10 is different from preceding sections; please use your knowledge of the burn unit/hospital in answering these questions. Examples:**

**4. Stethoscope**: this does not mean 1 in the hospital but do staff have access to a working stethoscope when they need one? Y/N
**10. Telephone**: is there one freely available for staff to use when needed. Y/N
**12. Analgesia oral/IM/IV**: not asking 'is it given', but 'do you have the appropriate medication'? If none available - No, if reasonable or full stock - Yes.
**28. Watson/Humby knife** – maybe there is one, but is it broken: do you have one for use by staff? Y/N
**38. Play area for children**: for instance a safe area *dedicated* to children where they can play (indoors or outdoors).
**50. Data collection support:** a service may collect data but is there administrative support for this? Admin support – Yes; done by Drs or nurses – No.

## Required in Basic level burn units

1. Standardised paper or electronic data registry
2. Burn assessment chart
3. Burn admission pro-forma
4. Stethoscope
5. Blood pressure cuff
6. Guedel airway
7. Bag and mask
8. IV fluids
9. IV cannulae
10. Telephone
11. Access to transport – taxi / rickshaw / ambulance?
12. Analgesia – oral / IM / IV
13. Access to chronic pain support
14. Antiseptic fluids – iodine / betadine /
15. Topical antimicrobials – what
16. Simple dressings - what
17. POP

## Required in Intermediate level burn units

18. Laryngoscope
19. Suction
20. Bougie
21. Endotracheal tubes
22. O2 supply – cylinder / concentrator / piped?
23. Ventilator
24. Central line kit
25. Basic surgical set
26. Operating theatre
27. Specific ward or area for burn patients
28. Watson / Humby knife
29. Mesher
30. Rehabilitation equipment
31. Splints
32. Laboratory support
33. Blood transfusion facility
34. NG tubes
35. Nutritional supplements
36. Dedicated physiotherapy area
37. Dedicated physiotherapy equipment
38. Play area for children
39. Lap top or desk top computer
40. Printer
41. Flip chart

## Required in Advanced level burn units

42. Designated critical care area
43. Dedicated burns theatre
44. Digital camera
45. Projector
46. Lecture theatre / seminar room
47. IT equipment
48. Reliable Internet access
49. Data management software
50. Data collection support
51. Library
52. Administrative support