The National Neonatal Surgical Benchmarking Group: Development of a benchmark for stoma management

The National Neonatal Surgical Benchmarking Group was set up following the identification of a need to share and develop the care delivered to the surgical neonate between units and base care on evidence-based guidelines. This article describes the clinical practice benchmarking process used by the group and gives as an example the outline of a benchmark for stoma management.

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Key points

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1. There is a need for evidence-based guidelines for treatment of neonates requiring surgery.
2. A benchmark provides a structure for sharing and comparison of clinical practice to identify best practice.
3. The National Neonatal Surgical Benchmarking Group was set up to enable practices to be shared and compared on a national basis to move practice forward.

Historically the complex care needs required by the surgical neonatal population used to be met by a regional approach, which could be a little isolating. Many of the nursing procedures are unique to this group of patients, without evidence or research to support them. Practices are often based on previous experience, individual surgeon preference or anecdotal report.

In the Newcastle regional unit, due to this lack of evidence-based guidelines, questions were asked about how practices compared with other units. Rather than simply contacting other units, this provided a unique opportunity to develop a benchmarking group on a national basis in order to share, compare and move practice forward.

Why set up a national benchmarking group?

Over ten years ago suggestions were made that benchmarking could be of value in supporting the development of best clinical practice[1]. It was felt that benchmarking provided a structure of sharing and comparison of clinical practice, and also, through the use of literature reviews and research and audit, the resultant practice would then be based on the highest level of available evidence. However, it is also accepted that where research has not been undertaken, or there is little evidence available, professional consensus of best possible achievable practice is the way forward[2]. Sharing examples of good practice allows the practioner to make a difference, ensuring consistently high standards of practice[3].

A First Class Service; Quality in the New NHS	(1998)
Clinical Governance Framework	(1999)
Making a difference	(1999)
The NHS Plan	(2000)
Essence of Care	(2001)
Essence of Care. Patient-focussed Benchmarks for Clinical Governance. NHS Modernisation Agency	(2003)

FIGURE 1. Clinical practice benchmarking from the NHS perspective – Department of Health references.

What is a benchmark?

A benchmark can be defined as a statement of best practice identified using available evidence, consumer views and through professional consensus[4]. The process of benchmarking is sharing, collaboration and support, with the aim of developing practice to achieve the benchmark. Clinical practice benchmarking is the process through which best practice is identified and continuous improvement pursued through comparison and sharing[2]. This is achieved through a systematic approach to the assessment of practice.

The process is a practioner led initiative, promoting ownership for staff and leading to increased motivation and morale. Benchmarking allows practices to become proactive and innovative[5]. Through the use of benchmarking the evidence produced promotes positive changes in clinical practice if necessary, and can also be used as evidence for the need for additional resources and/or risk management. Clinical Practice benchmarking from the NHS perspective is promoted in the documents shown in **FIGURE 1**.

The National Neonatal Surgical Benchmarking Group

Once the benchmarking process was understood the benefits of forming a National Neonatal Surgical Benchmarking Group became apparent. There was a very good response to the idea and membership has been well distributed from Glasgow to Southampton. The first meeting took place in Newcastle during March 2002, where a vision for the group was shared, ground rules set and a philosophy agreed.

Since the first meeting a good network has developed between all member units. Meetings are held every three months and rotate around the country, with guest speakers invited to discuss relevant topics. The meetings are also an excellent forum to share and compare experiences, for example regarding the management of gastroschisis. Non-surgical management has been developed amongst a number of units with varying degrees of success. Discussion of both positive and negative experiences provided the opportunity to share tips and advice.

The first area the group considered was in regard to wound management. From the initial evidence the need for a specific neonatal wound assessment tool became apparent. The group are devising a tool and wound management package which may be implemented in all units and audited on a national level. The group is also conducting a national audit looking at bowel washouts, in order to develop national guidelines for this procedure. The benchmark for stoma management is shown in **FIGURE 4**.

Development of a benchmark

It was agreed by the group that all the benchmarks would follow the format of the essence of care phases (**FIGURE 2**) and the benchmark cycle (**FIGURE 3**), as work is ongoing using this format and it keeps things uniform.

First a best practice statement is produced for a particular topic. This is developed by a thorough literature review of all the available articles on the subject by members of the group. The articles are critiqued and presented back to the group, a presentation is given at a meeting from a relevant expert, and individual unit's practices are shared and compared with the benchmark outcome. After consideration of all of the available evidence, the best possible outcome is developed.

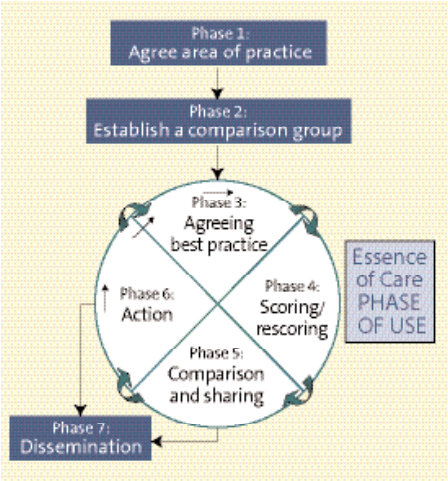

FIGURE 2. The Essence of Care. London, DoH. (2001)[4].

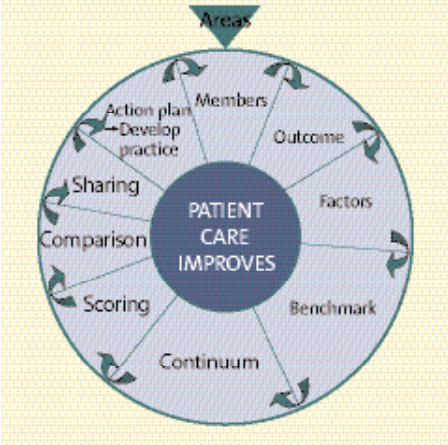

FIGURE 3. The benchmarking cycle[6].

In order to make the analysis of the best practice statement more manageable it is divided into factors each with an individual best practice statement as highlighted by Ellis[6]. Practitioners are asked to outline practices undertaken by their services which move practice forward or prohibit them from undertaking practice that moves toward the best practice statement. Included in each factor are statements to promote discussion, which aid the assessment of individual unit's practice. The benchmark is laid out in paper format to allow comments to be added and taken back to individual units where an assessment of practice is made using the benchmark.

The group made a conscious decision that scoring of practice would not be carried out as it was felt to be negative and it hindered the process as practioners found it difficult to score their area practice accurately. Ellis[2] highlights practitioner inconsistency with scoring and the difficulties this can cause. Ellis[5] does state that without scoring clinical practice benchmarking may be considered a quality assessment or audit activity. In our group evidence must be supplied to support practice statements, and also identify barriers that stop practice moving forward. Within the group, there is an open and honest forum where negative experiences are discussed openly and honestly, with support and advice available.

Once individual unit assessment is made, an action plan is developed to move practice forward, and good practice is highlighted. This is then presented back to the group and all experiences shared and compared, with help and support offered to all. The benchmark is then revisited approximately twelve months later, and practice is evaluated and up dated if necessary, and/or advances in practice discussed.

Each unit has drawn up very thorough action plans to move their practice forward and information is freely shared. The action plans are leading to exciting developments within this area.

Conclusion

Clinical practice benchmarking is essential in the development of practices. It promotes a culture of research and evidence-based practice, encouraging staff from all levels to be involved. Following the benchmarking process it is essential that learning and experiences are shared leading to innovative and proactive practices.

Participation in this exciting and innovative group provides an opportunity to promote the care of this unique group of children. The group plans to publish future work and develop a website providing a resource for all healthcare professionals.

References

1. **Ellis J.M.** Using benchmarking to improve practice. *Nursing Standard* 1995; 9(35): 25-28.
2. **Ellis J., Morris A.** Paediatric benchmarking: A review of its development. *Nursing Standard* 1997; 12(2): 43-46.
3. **Ellis J., Cooper A. et al.** Making a difference to practice: Clinical benchmarking part 1. *Nursing Standard* 2000; 14(32): 33-36.
4. **Loveridge N.B.** Benchmarking as a Quality assessment tool. *Emergency Nurse* 2002; 9(9): 24-29.
5. **Department of Health.** Making a Difference. London: The Stationary Office. 1999.
6. **Ellis J.** Sharing the evidence: Clinical practice benchmarking to improve continuously the quality of care. *J Adv Nursing* 2000; 32(1): 215-25.

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FIGURE 4: THE STOMA MANAGEMENT BENCHMARK

Overall best practice statement:

Optimal care and management of stomas will be achieved by utilising an evidence-based, family centred, and collaborative team approach.

To assess this benchmark please review the evidenced based benchmark statement, in relation to the practice in your own area. The statements to stimulate discussion are there to guide all staff to review various issues. They are pointers to help you to measure your own practice, but are not questions to be answered. When completing your response, please only write down relevant points of/or barriers to good practice. All explanations can be given and discussed at the comparison group meeting.

Factors

1. Preoperative care of the baby
2. Preparation of the family
3. Delivery of stoma care
4. Education and training of health professionals
5. Preparation for discharge/transfer

Factor One: Preoperative care of the infant requiring stoma formation

Best Practice Statement: To provide accurate and continuous assessment throughout the pre-operative period creating a structured tool for documenting holistic care.

Assessment – a formal comprehensive and systematic process in which a range of specific methods / tools can be used to identify and quantify the patient's risk.

Statements to stimulate discussion:

- Who undertakes assessment and how is this recorded?
- What assessment tool is used? What evidence base supports use of tool?
- How frequently is assessment made?
- What competencies/knowledge is required by the assessor?
- What mechanisms are in place for assessing the competencies of assessors?
- How is assessment accessed by the MDT?

Factor Two: Preparation of the family

Best Practice Statement: All families will receive appropriate information from the multidisciplinary team to enable them to fully participate in the decision making process and give informed consent.

Statements to stimulate discussion:

- State information available? Is this local or nationally produced? Aimed at parents? Is it available out of hours?
- Is a paediatric/neonatal stoma nurse available?
- Is a parental teaching pack available? Is their competence assessed and documented?
- State how information is adapted for different user groups and the individual needs of children, their families and carers
- Are there fact sheets, posters, leaflets, videos, translated materials?
- How is user acceptability of the information given audited? Surveyed? Analysed? How is feedback given? Parent satisfaction surveys?
- State measures taken to ensure awareness and access of available information.
- State evidence base for information and how this is evaluated to ensure that it is up to date and consistent
- State how cultural or linguistic needs are addressed.
- Is the full MDT team involved in the discussions?

Factor Three: Delivery of stoma care

Best Practice Statement: The assessment and planning of care is focussed upon the relevant neonatal issues and is evidence-based. Care is individualised, evaluated and documented.

Statements to stimulate discussion:

- Describe how treatment, interventions, targets are negotiated with the MDT.
- Demonstrate the evidence base that underpins care planning. How regularly are the plans reviewed and evaluated?
- Policies/procedures/guidelines in place?
- What equipment/products are available for delivery of stoma care?
- Is there an evidence based stoma care plan?

Factor Four: Education and training – health professionals

Best Practice Statement: All nursing and medical staff receive an evidence-based, consistent and comprehensive education/training programme and attend ongoing update sessions to maintain competencies.

Statements to stimulate discussion:

- State who delivers training to MDT and what it consists of?
- Who is responsible for maintenance of records? How are they maintained?
- What levels of knowledge do the HPs have who are delivering the training?
- What part do PDPs play
- Are there training plans/packages to follow? How often is the impact of training assessed and training updated?
- Are there competency assessments? How is it assessed (for HPs)?
- What documentation is used
- What resources are available for training? Room/presentation/mannequins/ equipment
- What is covered in the training to the Health Professional?
- Are update sessions undertaken?
- How do user views influence training?
- How is vicarious liability addressed?

Factor Five: Familial preparation for discharge/transfer

Best Practice Statement: All families/carers are competent and confident in meeting the infants' needs within the community setting. They have access to a supportive multidisciplinary team at all times.

'Children should be cared for at home with the support and practical assistance of community children's services, unless that care can only be provided in hospital.'

Statements to stimulate discussion:

- State information available? Is this local or nationally produced? Aimed at parents?
- State how information is adapted for different user groups and the individual needs of children, their families and carers
- Are there fact sheets, posters, leaflets, videos, translated materials?
- How is user acceptability of the information given audited? Surveyed? Analysed? How is feedback given? Parent satisfaction surveys?
- State measures taken to ensure awareness and access of available information. State evidence base for information and how this is evaluated to ensure that it is up to date and consistent
- State how cultural or linguistic needs are addressed.
- Is parental competency assessed and documented?