WM QRS West Midlands Quality Review Service

NHS

Care of Critically Ill & Critically Injured Children Quality Review Visit

Wye Valley NHS Trust

Visit Date: 28th June 2016 Version 2 Report Date: November 2016

Images courtesy of NHS Photo Library and Sandwell and West Birmingham Hospitals NHS Trust

UKAS INSPECTION 8831

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Version	Date	Changes from Previous Version
V2	09.11.16	Minor change of wording in Appendix 2: PE-214 comment regarding Emergency Department Consultant access within 30 minutes removed and PG-501 compliance amended to 'Yes'.

Introduction

This report presents the findings of the Care of Critically Ill & Critically Injured Children Quality Review Visit at Wye Valley NHS Trust that took place on 28th June 2016. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Care of Critically Ill and Critically Injured Children V5

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team that reviewed the services at Wye Valley NHS Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Wye Valley NHS Trust
- NHS Herefordshire Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Herefordshire Clinical Commissioning Group.

About West Midlands Quality Review Service

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews – often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

Acknowledgments

West Midlands Quality Review Service would like to thank the staff and service users and carers of Wye Valley NHS Trust and NHS Herefordshire CCG for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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TRUST-WIDE

General Comments and Achievements

All staff who met the visiting team were welcoming, open and honest about the services provided. The Trust had prepared well for the review visit. Good teamwork was evident, with departments cooperating well in their care of critically ill and critically injured children. Staff were well aware of the areas that needed to be addressed, and plans and processes were in place to achieve the necessary improvements. An appropriately trained paediatric resuscitation team was available on site.

Reviewers also commended the Trust on being reviewed against Version 5 of the WMQRS Quality Standards for the Care of Critically Ill and Critically Injured Children. These Standards had been available only since January 2016 and Wye Valley NHS Trust was the first Trust to be reviewed against them.

Immediate Risks[1]

1 Arrangements for time-critical (primary) transfers were not robust, and some staff did not appear to realise that these could be part of their responsibilities. The transfer policy did not include enough detail for it to be used effectively by, for example, a locum doctor. The 'grab bag' for time-critical transfers was not set up with the necessary equipment, and reviewers considered that finding the equipment required could take a long time and mistakes or omissions could occur. It was not clear that all on call anaesthetists would be prepared to accompany a time-critical transfer, and scenario training did not take place regularly. Reviewers recognised that time-critical transfers happen rarely but did not consider the Trust was adequately prepared.

Further Consideration

1 The criteria for surgery on children were broad and may benefit from additional detail in relation to age, clinical condition and co-morbidities, time of day, and expertise available within the hospital. In particular, the criteria were not clear about arrangements when the surgeon with an interest in the care of children was not available.

2 The expected information for children, young people and their parents was available but reviewers made some suggestions about how this could be improved:

   a. A lot of information for young children was available but there was relatively little information for older children.

   b. The paediatric waiting area in the Emergency Department had little of the information required by the Quality Standards. This information was available in the main waiting area but children and families would not be likely to see it there.

   c. The feedback form on the paediatric ward was designed for parents or carers to fill in on behalf of their child. The questions were quite superficial and did not probe the child's experience of the care provided. Reviewers suggested that a feedback form for children and young people, separate from their parents' form, would be helpful.

   d. A lot of information was available but reviewers considered that it might not always have been in the most appropriate location. Responsibilities and arrangements for giving information to children, young people and parents were not always clear.

[1] **Trust Response:** The Transfer Policy has now been updated and now includes responsibilities of staff. The Trust has now produced a new Paediatric Grab Bag on ITU which could be used in these rare situations of time critical transfers. You have also asked for clarity about the on call anaesthetists not being prepared to accompany a time-critical transfer and mandatory scenario training not taking place on a regular basis. This has now been strengthened within the Transfer Policy.
WMQRS Response: The actions taken mitigate the immediate risk identified at the visit. The revised transfer policy covers the issues identified.

e. Some documents repeated information and it was not clear which document was actually used. For example, reviewers saw two or three versions of the paediatric ward 'welcome booklet' but were not clear which would be used when.

f. Information for children needing surgery was available but it was not clear whether this was always given out at pre-assessment.

3 The resuscitation officer used a system of separate resuscitation training records because it was difficult to ensure that records on the Trust-wide system were kept up to date. Separate records meant that it was difficult for managers to have an overview of the resuscitation training of staff in their department.

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EMERGENCY DEPARTMENT

General Comments and Achievements

Staff in the Emergency Department were working to improve the pathway of care and the environment. Cubicles used for children had appropriate decoration for young children. A good 'all about me' booklet was in use. Rotation of nursing staff between the Emergency Department and paediatric ward was in place. The patient handover sheet included a 'safety lesson of the week'.

Good Practice

1 A monthly feedback newsletter to all staff included lessons learnt from incidents and complaints as well as news on other events.

Concerns

1 **Up to date, appropriate paediatric life support training**

Based on the evidence available, approximately 50% of consultant and middle grade doctors working in the Emergency Department did not have up to date, appropriate level paediatric life support training. Support would be available from the paediatric resuscitation team. Reviewers also recognised that some staff may have completed appropriate training that had not yet been recorded on the Trust system.

2 **Safeguarding training**

Based on the evidence available, eight out of 17 medical staff working in the Emergency Department did not have up to date training in safeguarding children; one of these members of staff worked permanent night shifts and was shown as not having completed any mandatory training. Reviewers were also concerned that nine medical staff were shown as needing level 2 safeguarding children training whereas the Trust's safeguarding lead said that all clinical staff in the Emergency Department should have level 3 training. Reviewers were told that all nurses working in the Emergency Department had completed level 3 safeguarding training but data to confirm this were not available.

Further Consideration

1 A children's trained nurse was not always available, partly because one member of staff was on maternity leave. Support for the care of sick children in the Emergency Department was provided by nursing staff from the paediatric ward.

2 See Trust-wide section of this report in relation to information for children, young people and families.

3 Work was planned in relation to nursing competences, which would be supported by the nurse educator from the paediatric ward. Reviewers considered that this would be helpful for staff in the Emergency Department.

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Integrated In-Patient Service and Level 1 Paediatric Critical Care

General Comments and Achievements

Paediatric services were well-organised, with well-documented processes and clear plans for addressing outstanding issues. A good 'all about me' booklet was in use. Reviewers were also impressed by the environment, including the adolescent area and the room for teenagers. Facilities for parents were very good. Good feedback arrangements were in place (although see 'further consideration' section below), and included the opportunity for children to give their views. Feedback seen by reviewers was particularly positive about the contribution made by play specialists during patients' care. Registered nursing staff had a high level of training in advanced life support. Rotation of nursing staff between the Emergency Department and paediatric ward was in place. Reviewers were particularly impressed by the level of consultant paediatrician input, including into the care of children needing surgery.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration:

1 Nurse staffing on the paediatric ward at night appeared low. Two registered nurses were on duty at night for 16 in-patient beds, four Paediatric Assessment Unit beds that were occasionally also used overnight, and one cubicle that was used for Level 1 paediatric critical care. In winter there were three registered nurses on duty at night. Paediatric nurses also supported the Emergency Department if a sick child arrived, and provided 1:1 nursing for children needing Level 1 critical care. Bank and agency staff would be brought in if the ward was very busy. Reviewers did not have information on occupancy levels on the ward, or about how often critical care was provided or staff went to the Emergency Department.

2 See Trust-wide section of this report in relation to information for children, young people and families.

3 Good work was in progress relating to nursing competences, and reviewers supported the continuation of this work.

4 CO_2 monitoring equipment was not available on the paediatric ward, and portable monitoring equipment was brought from theatre if required. Young children were ventilated on the ward and reviewers suggested that monitoring equipment should be available there.

5 See paediatric anaesthesia section of this report in relation to the care of 16- and 17-year-olds needing critical care.

Paediatric Anaesthesia & General Intensive Care Unit

General Comments and Achievements

Paediatric anaesthesia staff were clearly committed to providing good care for children. In particular, staff working in recovery were enthusiastic and all, except some newly appointed staff, had completed PILS training.

Good Practice

1 A good leaflet was available on pregnancy testing for girls aged under 16.

2 Pre-filled drug boxes in theatres meant that drugs were easily accessible when needed.

Immediate Risks: See Trust-wide section of this report.

Concerns

1 **Up to date competence in advanced paediatric resuscitation and life support and advanced airway management**

Reviewers were not convinced that all consultant anaesthetists with emergency responsibility for children had up to date competences in advanced paediatric resuscitation and life support and advanced airway management. Anaesthetists without up to date competences had been identified, and had been asked to read the latest guidance and watch a video. Reviewers did not consider that this level of updating would give sufficient competence and confidence. (NB. This issue links with the immediate risk identified in the Trust-wide section of this report.)

Further Consideration

1 Theatre staff used the paediatric resuscitation trolley located in the general intensive care unit. Reviewers suggested that locating a sealed trolley in the recovery area would be more appropriate, and supported plans for provision of a trolley that would be similar to that on the paediatric ward.

2 See Trust-wide section of this report in relation to information for children, young people and families.

3 As in other parts of the region, arrangements for the care of 16- and 17-year-olds needing critical care, including those cared for on the general intensive care unit prior to transfer to a more appropriate setting, were not clear. Reviewers suggested that intensive care unit staff should consider their approach to providing care for this group of patients, in collaboration with paediatric medical staff. Reviewers considered that paediatric medical staff could not take lead responsibility for patients needing critical care on the general intensive care unit, although they could provide advice and support.

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COMMISSIONING

General Comments and Achievements

Commissioners had a good understanding of the services provided, appropriate monitoring arrangements were in place and commissioners had good relationships with staff at Wye Valley NHS Trust.

Further Consideration

1 Only two days a week of commissioning resource was available for commissioning all services for children. Reviewers considered this level of resource was very low for the amount of work required.

Concerns

1 Other sections of this report identify issues that require commissioner attention:

a. Time-critical transfers: See Trust-wide section, Immediate Risk

b. Up to date, appropriate paediatric life support training: See Emergency Department, Concern 1

c. Safeguarding training: See Emergency Department, Concern 2

d. Up to date competence in advanced paediatric resuscitation and life support and advanced airway management: See Paediatric Anaesthesia & General Intensive Care Unit, Concern 1

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Abigail Akita	Consultant Anaesthetist	The Royal Wolverhampton NHS Trust
Dr Julie Brent	Consultant Paediatrician – Oncology	The Royal Wolverhampton NHS Trust
Dr James Davidson	Associate Medical Director	University Hospitals Coventry & Warwickshire NHS Trust
Fiona Ellis	Commissioning and Redesign Lead – Women's and Children's Strategy & Service Redesign	NHS Shropshire CCG
Lindsey Hodges	User Representative	
Zoë Morris	User Representative	
Dr Gale Pearson	Consultant Intensivist, PICU	Birmingham Children's Hospital NHS Foundation Trust
Helen Whitehouse	Senior Paediatric Emergency Nurse Practitioner	Heart of England NHS Foundation Trust
Caroline Whyte	Paediatric Matron	Walsall Healthcare NHS Trust

Observers

Louise Sanders	Assessment Manager	UK Accreditation Service
Dr Stephen Playfor	Technical Expert	UK Accreditation Service

WMQRS Team

Jane Eminson	Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 – Percentage of Quality Standards met

Service	Number of applicable QS	Number of QS met	% met
Trust-wide	11	6	55
Emergency Department	42	32	76
Integrated In-Patient Service and Level 1 Paediatric Critical Care	38	31	82
Paediatric Anaesthesia & General Intensive Care Unit	24	16	67
Commissioning	5	2	40
Total	120	87	73

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TRUST-WIDE

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-201	**Board-Level Lead for Children** A Board-level lead for children's services should be identified.	N	A single Board-level lead for children was not identified. Individual elements of children's services were reflected in the responsibilities for appropriate executive and non-executive directors.
PC-202	**Clinical Leads** The Board-level lead for children's services should ensure that the following leads for the care of children have been identified: a. Lead consultants and nurses for each of the areas where children may be critically ill (QS PM-201) b. Lead consultant for paediatric critical care c. Lead consultant for surgery in children (if applicable) d. Lead consultant for trauma in children (if applicable) e. Lead anaesthetist for children (QS PG-201) f. Lead anaesthetist for paediatric critical care (QS PG-202) g. Lead GICU consultant for children (QS PG-203) (if applicable) h. Lead consultant/s and lead nurse/s for the Specialist Paediatric Transport Service (QS PT-201) (if applicable) i. Lead consultant and lead nurse and for safeguarding children j. Lead allied health professional for the care of critically ill children	Y	
PC-203	**Trust-Wide Group** Trusts providing hospital services for children should have a single group responsible for the coordination and development of care of critically ill and critically injured children. The membership of this group should include all nominated leads (QS PC-202) and the Resuscitation Officer with lead responsibility for children. The accountability of the group should include the Trust Lead for children's services (QS PC-201). The relationship of the group to the Trust's mechanisms for safeguarding children and clinical governance issues relating to children should be clear.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-204	**Paediatric Resuscitation Team** A paediatric resuscitation team should be immediately available at all times, comprising at least three people: a. A Team Leader with up to date advanced paediatric resuscitation and life support knowledge and competences and at least Level 1 RCPCH (or equivalent) competences (QS PM-203) b. A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences c. An anaesthetist or other doctor with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management	Y	Membership of the resuscitation team was described in the resuscitation policy.
PC-205	**Consultant Anaesthetist 24 Hour Cover** A consultant anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management who is able to attend the hospital within 30 minutes and does not have responsibilities to other hospital sites should be available 24/7.	N	See main report.
PC-206	**Other Clinical Areas** Staff in other clinical areas where children may be critically ill, such as imaging and paediatric out-patient departments, should have basic paediatric resuscitation and life support training.	N	The Resuscitation Offer reported that 80-90% of staff had appropriate training but documentary evidence to support this was not available. The expected level of resuscitation training for theatre staff was not clear (ie. whether all needed paediatric basic life support training or only those in contact with children).
PC-401	**Paediatric Resuscitation Team – Equipment** The paediatric resuscitation team should have immediate access to appropriate drugs and equipment which are checked in accordance with local policy.	Y	
PC-501	**Resuscitation and Stabilisation** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child	Y	The revised policy was awaiting Trust ratification.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-502	**Surgery and Anaesthesia Criteria** Trust-Wide guidelines on criteria for surgery and anaesthesia for children should be in use covering: a. Elective and emergency surgical procedures undertaken on children of different ages b. Day case criteria c. Non-surgical procedures requiring anaesthesia or conscious sedation	N	A one-sheet Standard Operating Procedure was available which did not include day case criteria ('c').
PC-598	**Trust-Wide Guidelines** The following Trust-Wide guidelines should be in use: a. Consent b. Organ and tissue donation c. Palliative care d. Bereavement e. Staff acting outside their area of competence covering: i. Exceptional circumstances when this may occur ii. Staff responsibilities iii. Reporting of event as an untoward clinical incident iv. Support for staff	N	'a' to 'd' were being updated at the time of the review visit. There was no specific policy covering 'e'.
PC-602	**Paediatric Critical Care Operational Delivery Network Involvement** At least one representative from the Trust should attend each meeting of the Paediatric Critical Care Operational Delivery Network. Information about the work of the network should be disseminated to all staff involved in the provision of critical care for children.	Y	Mechanisms for dissemination of information were not clear but staff were generally aware of the work of the network.

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EMERGENCY DEPARTMENT

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-101	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities.	Y	
PM-102	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child	Y	
PM-103	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available.	Y	Information was not easily available and it was not clear to reviewers if it was routinely given to children and parents. Reviewers suggested that information may be better displayed in the Emergency Department waiting area. The pictures and visual displays were good.
PM-104	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Relevant support groups and voluntary organisations	Y	Some information was displayed in the adult waiting room but may not be seen if children were directed to the children's waiting room.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-196	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details	Y	
PM-197	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services	Y	
PM-199	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families	Y	A range of evidence of changes made as a result of feedback from young people and parents was available.
PM-201	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.	Y	
PM-202	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children	N	From the information available at the visit approximately 50% of consultants did not have appropriate level, up to date, paediatric resuscitation training.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-203	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be Specialist Trainee 4 (ST4) or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.	N	From the information available at the visit approximately 50% of middle-grade medical staff did not have advanced paediatric life support training.
PM-206	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS PM-208) and expected input to the paediatric resuscitation team (QS PC-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems	Y	The competence framework seen by the reviewers may benefit from review to include more detail. The Nurse Educator from the ward was in the process of reviewing the Emergency Department staff competences.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-207	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least one registered children's nurses on duty at all times in each area	N	An RCN with the relevant competences in paediatric care was not always on duty, partly due to a maternity leave. Reviewers were told that there were nurse vacancies. All band 6 staff were EPLS (European Paediatric Life Support) trained although there were gaps in training evidence seen for band 5 staff.
PM-209	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) c. Access to dietetic service (at least 5/7) d. Access to a liaison health worker for children with mental health needs (7/7) e. Access to staff with competences in psychological support (at least 5/7)	N	'a' was not applicable due to the small number of attendances. A range of 'distraction boxes' could be utilised. 'b': access out of hours was via the on call pharmacist. 'c' was met. 'd': CAMHS could be contacted during the day but children would be admitted and seen on the ward outside normal working hours. 'e': There was no access to staff with competences in psychological support.
PE-211	**ED Liaison Paediatrician** A nominated paediatric consultant should be responsible for liaison with the nominated Emergency Department consultant (QS PM-201).	Y	
PE-212	**ED Sub-speciality Trained Consultant** Emergency Departments seeing 16,000 or more child attendances per year should have a consultant with sub-specialty training in paediatric emergency medicine.	N/A	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-213	**Small Emergency Departments** Emergency Departments seeing less than 16,000 child attendances per year should have arrangements in place to ensure the ongoing competence of clinical staff in the care of critically ill children.	Y	Consultants had undertaken a range of Continuing Professional Development relating to the care of children. Middle grade medical staff were also released to attend regional training which included paediatrics.
PE-214	**Trauma Team** Emergency Departments receiving children with trauma should have a Trauma Team immediately available at all times, including: a. Team Leader b. Emergency Department senior decision-maker c. Clinician with Level 1 RCPCH competences d. General Surgeon e. Orthopaedic Surgeon f. Anaesthetist with competences in advanced airway management (QS PC-204)	N	It was not clear if the Trauma Team was operational outside of normal working hours.
PM-298	**Safeguarding Training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role, as agreed by the Trust and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the Trust and local Safeguarding Board	N	Data shown to the reviewers showed that only 50% of medical staff had safeguarding training. It was not clear if all Emergency Department clinicians had level 3 safeguarding training. Reviewers were told that all Emergency Department nurses were trained to level 3 but data were not available to support this.
PM-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	
PM-301	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Trust should have arrangements for review of imaging by a paediatric radiologist.	Y	
PM-401	**Resuscitation Equipment** An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.	Y	Documentation of checks could be more robust.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-402	**Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.	N	Seen main report
PE-403	**Facilities for Children** At least one clinical cubicle or trolley space for every 5,000 annual child attendances should be dedicated to the care of children.	Y	
PM-406	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.	Y	
PM-501	**Initial Assessment** A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.	Y	From 10am to 10pm two staff were available to triage. A process for escalating for more paediatric support was in place if there were multiple paediatric attendances in the department.
PM-502	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.	Y	
PM-503	**Resuscitation and Stabilisation** Trust-Wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child	Y	Revised guidelines were with the Trust governance group for approval.
PM-504	**Paediatric Advice** Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-505	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation	N	Child-specific paediatric trauma guidelines were not yet in place. Sepsis guidance seen at the time of the visit covered only meningococcal infection.
PM-506	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained	Y	
PM-507	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.	Y	Guidelines were not detailed and did not provide enough information for them to be used by a locum in an emergency.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-508	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer	Y	
PM-509	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS PM-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS PM-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer	Y	Guidelines were limited. See also main report in relation to staff awareness of the need for time-critical transfers and their preparedness to undertake this.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-510	**Trauma Guidelines** Guidelines on the care of children with trauma should be in use covering: a. Handling calls received on the dedicated trauma phone b. Alerting and activating the Trauma Team (QS PE-214) c. Handover from the pre-hospital team to the Trauma Team lead d. Responsibilities of members of the Trauma Team, including responsibility for: i. Liaison with families ii. Calling all relevant consultants iii. Safeguarding children and vulnerable adults e. Involvement of a paediatric neurosurgeon in all decisions to operate on children with traumatic brain injury f. Indications and arrangements for referral to the Major Trauma Centre for children, including referral of children needing assessment for: i. Neurosurgery ii. Vascular surgery iii. Cardiothoracic surgery iv. Spinal cord service v. Specialist paediatric surgery vi. Other specialist surgery g. Handover of children no longer needing the care of the Trauma Team h. Completing standardised documentation i. Major incidents	N	Child-specific paediatric trauma guidelines were not yet in place.
PE-511	**Trauma Clinical Guidelines** Guidelines should be in use covering the care of children with trauma, including: a. Immediate airway management b. Haemorrhage control and massive transfusion c. Chest drain insertion	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-512	**Trauma Imaging Guidelines** Guidelines on imaging of children with trauma should be in use covering at least: a. Imaging modalities and indications b. Liaison with a radiologist to agree an imaging plan c. Timescales for undertaking imaging d. Indications and arrangements for review of imaging by a neuro-radiologist e. Timescales for provisional and final reporting f. Electronic transmission of images g. Responsibilities for recording receipt of imaging reports h. Monitoring achievement of expected timescales: i. CT scanning within 30 minutes of arrival ii. Provisional report issued within one hour iii. Full report issued within 12 hours i. Communication of any significant variations between the provisional and final reporting	Y	Guidelines were not detailed and did not provide enough information for them to be used by a locum in an emergency.
PM-598	**Implementation of Trust Guidelines** Staff should be aware of and following Trust guidelines (QS PC-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence	Y	Staff were aware of the guidelines that were available.
PM-601	**Operational Policy** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate	N	An operational policy covering all the requirements of the Quality Standard was not yet in place. 'c' had not yet been considered.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-602	**Urgent Care Centres** If the Trust's services include an Urgent Care Centre, this Centre should have: a. At least one clinician with advanced paediatric resuscitation and life support competences is available on site at all times the service is open b. Appropriate drugs and equipment for a paediatric resuscitation, including a defibrillator, oxygen and suction c. Guidelines in use in the event of a critically ill child, or potentially critically ill child, presenting. The guidelines should include transfer to an appropriate paediatric unit	N/A	
PE-603	**Emergency Centres for Adults Only – Avoiding Child Attendances** Hospitals without on-site assessment or in-patient services for children should: a. Indicate clearly to the public the nature of the service provided for children b. Have agreed a protocol with the local ambulance service that children are not brought to the service by ambulance c. Have arrangements for accessing paediatric medical advice and appropriate anaesthetic input to the care of a child	N/A	
PE-701	**Data Collection** The service should collect and submit Trauma Audit Research Network data and should review their performance compared with other units on a regular basis.	Y	
PM-703	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS PM-500s) b. Participation in agreed national and network-wide audits c. Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations	Y	
PM-704	**Key Performance Indicators** Key performance indicators should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-798	**Review and Learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.	Y	Feedback to staff was robust and there was also a monthly feedback newsletter.
PM-799	**Document Control** All policies, procedures and guidelines and should comply with Trust document control procedures.	Y	Updated resuscitation and transfer policies were awaiting Trust approval.

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Integrated In-Patient Service and Level 1 Paediatric Critical Care

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-101	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities.	Y	In general the environment was good for young children. There was an adolescent area on the ward but overall the environment was not ideal for teenagers.
PM-102	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-103	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available.	Y	A complaints leaflet had been designed specifically for children and feedback for children was provided at child level. In the paediatric assessment area much of the information displayed were aimed at parents although reviewers were told that condition-specific information was given to children. The 'All about me' booklet was very comprehensive. The welcome leaflet appeared to cater for both parents and children and reviewers considered that it may be helpful to separate the information available.
PM-104	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Layout of the unit or ward, visiting arrangements including arrangements for children to visit, car parking advice, ward routines and location of facilities within the hospital that families may wish to use g. Relevant support groups and voluntary organisations	Y	Good Polish leaflets were available. Reviewers commented that it would be easier to see the information if leaflets were not stapled to the wall. 'd': Psychological support was not available unless young people were known to be at risk of self-harm, in which case they were directed to Child and Adolescent Mental Health Services.
PM-105	**Facilities and Support for Families** Facilities should be available for families, including: a. Somewhere to sit away from the ward b. Quiet room for relatives c. Kitchen, toilet and washing area d. Changing area for other young children e. Midwifery and breast feeding support f. Breast feeding facilities g. Chair for parents to sit next to the child h. Access to psychological support	Y	Facilities were very pleasant, although parents who met with the visiting team commented that a bedside light would be helpful. See PM-209 regarding access to psychological support.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-196	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details	Y	The team was piloting a new discharge leaflet which was very good. Reviewers commented that the information about early warning signs of problems and what to do if these occur could be clearer.
PM-197	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services	Y	Bereavement support was provided in conjunction with the local hospice.
PM-199	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families	Y	A range of evidence of changes made as a result of feedback from young people and parents was available.
PM-201	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.	Y	
PM-202	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-203	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.	Y	
PM-205	**Medical Staff: Continuity of Care** Consultant rotas should be organised to give reasonable continuity of care.	Y	
PM-206	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS PM-208) and expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems f. Appropriate level paediatric critical care competences: 70% of nursing staff working on the PCC Units should have appropriate level competences in paediatric critical care.	N	Approximately 50% of clinical support workers had up to date training in paediatric basic life support. Some registered nurse had EPLS (European Paediatric Life Support) and 'preceptorship' training was in place. Work on implementing the 'critical care passport' had started. Two staff had completed the High Dependency Care course. Competences covering use of equipment and care of children with mental health problems were not yet in place. The Nurse Educator was in the process of reviewing competences and working with staff.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-207	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area c. At least one nurse per shift with appropriate level competences in paediatric critical care d. One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 critical care	N	The minimum nurse staffing levels were not met for 'c' or 'd'. There had been an increase in staffing level to three registered nurses at night during the winter months. Reviewers suggested that staffing levels should be kept under review (see main report).
PM-208	**New Starters** Nurses and non-registered health care staff without previous paediatric critical care experience should undertake: a. A structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the PCC Unit (or in a higher level unit) b. A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months Nurses and non-registered health care staff with previous paediatric critical care experience should complete local induction and a review of competence for their expected role.	N	See Quality Standard PM-206

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-209	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. Access to a liaison health worker for children with mental health needs (7/7) c. Access to staff with competences in psychological support (at least 5/7) d. Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit) e. Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit) f. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) g. Access to dietetic service (at least 5/7) h. Access to an educator for the training, education and continuing professional development of staff	N	Feedback about the play specialist was very positive (see main report). Support workers also supported play. 'b' was only available during weekdays. 'c': There was no access to staff with competences in psychological support. 'd': The pharmacist did not have time allocated for work on the ward but was available when contacted. 'e': The physiotherapist did not have time allocated for work on the ward but was available when contacted. 'f', 'g' and 'h' were met.
PM-298	**Safeguarding Training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role, as agreed by the Trust and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the Trust and local Safeguarding Board	Y	From the evidence seen, two consultants did not have documented training. Reviewers were told that all consultants did have up to date safeguarding training.
PM-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	
PM-301	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Trust should have arrangements for review of imaging by a paediatric radiologist.	Y	
PM-401	**Resuscitation Equipment** An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-402	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.	N	See main report
PM-404	**Facilities** Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care.	Y	
PM-405	**Equipment** Equipment, including disposables, should be appropriate for the usual number and age of children and the critical care interventions provided. Equipment should be checked in accordance with local policy.	N	Young people were ventilated on the ward but portable CO^2 monitoring equipment had to be used (see main report).
PM-406	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.	Y	
PM-501	**Initial Assessment** A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.	Y	Reviewers considered that specifying assessment within 15 minutes of arrival in the initial assessment documentation may be helpful. Initial Assessment within 15 minutes was included in the operational policy.
PM-502	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.	Y	
PM-503	**Resuscitation and Stabilisation** Trust-wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child	Y	Revised guidelines were with the Trust governance group for approval.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-505	**Clinical Guidelines** The following clinical guidelines should be in use: **All:** a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) j. Rehabilitation after critical illness (if applicable)	Y	'v' was not applicable to the ward.
PM-506	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained	Y	
PM-507	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-508	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer	Y	
PM-509	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS PM-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS PM-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer	Y	Guidelines were limited. See also main report in relation to staff awareness of the need for time-critical transfers and their preparedness to undertake this.
PM-598	**Implementation of Trust Guidelines** Staff should be aware of and following Trust guidelines (QS HW-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence	Y	Staff were aware of the guidelines that were available.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-601	**Operational Policy** **All:** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for a consultant-led rapid access service which can see children within 24 hours of referral g. Arrangements for admission within four hours of the decision to admit h. Types of patient admitted i. Review by a senior clinician within four hours of admission j. Discussion with a consultant within four hours of admission k. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours l. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff m. Discussion with a senior clinician prior to discharge	Y	
PM-702	**Data Collection** The service should collect: a. Paediatric Intensive Care Audit Network (PICANet) data b. Paediatric Critical Care Minimum Data Set for submission to Secondary Uses Service (SUS) c. 'Quality Dashboard' data as recommended by the PCC Clinical Reference Group (CRG)	N/A	
PM-703	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS PM-500s) b. Participation in agreed national and network-wide audits c. Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations	N	'c' was not yet in place. Other audits as defined by the Quality Standard were undertaken.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-704	**Key Performance Indicators** Key performance indicators should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	
PM-798	**Review and Learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.	Y	A governance structure was in place. Mortality and morbidity meetings were not in place but there were debrief meetings held following a child death. 'KIDS' also held meetings with staff on a regular basis. Arrangements for feedback to all levels of staff could be clearer.
PM-799	**Document Control** All policies, procedures and guidelines and should comply with Trust document control procedures.	Y	Updated resuscitation and transfer policies were awaiting Trust approval.

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PAEDIATRIC ANAESTHESIA & GENERAL INTENSIVE CARE UNIT

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PG-101	**Information on Anaesthesia** Age-appropriate information about anaesthesia should be available for children and families.	Y	Royal College leaflets were available although it was not clear if these were given out at pre-assessment.
PG-199	**Involving Children and Families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service	N	An audit had started. A survey of pain relief had been undertaken previously. Evidence of 'b' was not available.
PG-201	**Lead Anaesthetist** A nominated consultant anaesthetist should be responsible for policies and procedures relating to emergency and elective anaesthesia of children. This consultant should be involved in the delivery of anaesthetic services to children.	Y	
PG-202	**Lead Anaesthetist for Paediatric Critical Care (PCC units only)** A nominated consultant anaesthetist should have lead responsibility for support to paediatric critical care.	Y	
PG-203	**GICU Lead Consultant and Lead Nurse for Children** A nominated lead intensive care consultant and lead nurse should be responsible for Intensive Care Unit policies, procedures and training relating to the care of children.	Y	
PG-204	**On Site Anaesthetist** An anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management should be immediately available at all times.	N	See main report
PG-205	**Consultant Anaesthetist 24 Hour Cover** A consultant anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management who is able to attend the hospital within 30 minutes and does not have responsibilities to other hospital sites should be available 24/7.	N	See main report.
PG-206	**Medical Staff Caring for Children** All anaesthetists or intensivists with emergency and / or elective paediatric responsibility should have up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management.	N	See main report.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PG-207	**Elective Anaesthesia** All anaesthetists involved in the elective surgical management of children should be familiar with current practice and the techniques necessary to provide safe care for children, including acute pain management.	Y	Only one surgeon routinely undertook elective general paediatric surgery and no contingency plan to cover absences. Elective or emergency cases that could not be operated on in Hereford were transferred elsewhere.
PG-208	**Operating Department Assistance** Operating department assistance from personnel trained and familiar with paediatric work and competences in basic paediatric resuscitation and life support should be available for all emergency and elective children's surgery. For hospitals accepting children with trauma, this includes competences in the care of children with trauma.	N	Not all Operating Department Assistants were regularly involved with paediatric lists. There were insufficient staff available to pair experienced and in-experienced staff. Outside normal working hours an ODP could be on duty who had not seen a child recently. Only 9/17 ODAs had completed PILS training.
PG-209	**Recovery Staff** At least one member of the recovery room staff with paediatric resuscitation and life support competences should be available for all children's operating lists.	Y	Recovery staff were very enthusiastic. All recovery staff had completed PILS training. Some new staff had PBLS but would undertake PILS training when they were more experienced.
PG-401	**Induction and Recovery Areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	N	The QS was not met for the induction rooms. Distraction boxes were available for use. There was visual but not sound separation in the recovery area. The areas had some pictorial stickers in the bays that were used to recover children, though reviewers wondered if the hand painted murals seen in other areas could be replicated in these areas. Parents could enter the areas via a separate entrance.
PG-402	**Day Surgery** Children needing elective surgery should be admitted to a day surgery unit or a children's ward area specifically identified for children's day surgery.	Y	
PG-403	**Drugs and Equipment** Appropriate drugs and equipment should be available in each area in which anaesthesia is delivered to children. Drugs and equipment should be checked in accordance with local policy.	Y	Paediatric anaesthetists had their own version of the drug checklist. See main report in relation to paediatric resuscitation trolley in recovery area.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PG-404	**GICU Paediatric Area** The General Intensive Care Unit should have an appropriately designed and equipped area for providing paediatric critical care for children. Drugs and equipment appropriate to the age and condition of children who may be admitted (QS PM-506) should be available and checked in accordance with local policy.	Y	Children were admitted to a side room if possible.
PG-501	Role of Anaesthetic Service in Care of Critically Ill Children Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer and of critically ill children and the provision of paediatric critical care should be clear about the role of the anaesthetic service and General Intensive Care Unit (if applicable) in each stage of the child's care.	Y	
PG-502	**GICU Care of Children** If the maintenance guidelines in QS PM-506 include the use of a General Intensive Care Unit, they should specify: a. The circumstances under which a child will be admitted to and stay on the General Intensive Care Unit b. Availability of a registered children's nurse to support the care of the child and to review the child at least every 12 hours c. Discussion with a L3 PCC consultant about the child's condition prior to admission and regularly during their stay on the General Intensive Care Unit d. Agreement by a local paediatrician to the child being moved to the Intensive Care Unit e. Availability of a local paediatrician for advice f. Review of the child by a senior member of the paediatric team at least every 12 hours during their stay on the General Intensive Care Unit g. 24 hour access for parents to visit their child	Y	
PG-503	**Clinical Guidelines - Anaesthesia** Clinical guidelines should be in use covering: a. Pain management for children b. Pre-operative assessment c. Preparation of all children undergoing general anaesthesia d. Difficult airway management	N	Reviewers did not see documentation relating to 'b' and 'c' , although these happened in practice.
PG-598	**Implementation of Trust Guidelines** Staff should be aware of and following Trust guidelines: a. Surgery and anaesthesia for children (QS PC-502) b. Consent c. Organ and tissue donation d. Staff acting outside their area of competence	N	Staff were aware of the guidelines that were available.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PG-601	**Liaison with Theatre Manager** There should be close liaison between the lead consultant for paediatric anaesthesia (QS PG-201) and the Theatre Manager with regard to the training and mentoring of support staff.	Y	Two lead ODPs were proactive in delivering scenario training.
PG-602	**Children's Lists** Wherever possible, elective surgery on children should be undertaken on dedicated operating lists for children. If dedicated lists are not feasible, children should be put at the start of lists with appropriately trained staff in the reception, anaesthetic room, theatre and recovery areas.	Y	
PG-701	**GICU Critical Care Minimum Data Set** The critical care minimum data set collected and submitted to SUS should include data on children and young people admitted to the unit.	Y	
PG-798	**Review and Learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.	Y	
PG-799	**Document Control** All policies, procedures and guidelines and should comply with Trust document control procedures.	Y	

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COMMISSIONING

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PZ-601	**Paediatric Critical Care Needs Assessment and Strategy** Commissioners should have an agreed paediatric critical care: a. Needs assessment b. Strategy for the development of services across the Paediatric Critical Care Operational Delivery Network	N	Reviewers did not see a paediatric critical care needs assessment. A children's needs assessment and strategy which included critical care had been completed and implementation was being monitored.
PZ-602	**Commissioning: Urgent Care for Children** Urgent care for children from the network's population should be commissioned including: a. Emergency Centres b. Trauma services for children and their designation c. Children's Assessment Services	Y	
PZ-603	**Commissioning: Paediatric Critical Care** Paediatric critical care services for the network population should be commissioned including: a. Level 1 paediatric critical care service/s b. Level 2 paediatric critical care service/s c. Level 3 paediatric critical care services/s d. Specialist Paediatric Transport Service, including whether commissioned for aeromedical transfers e. Extracorporeal membrane oxygenation (ECMO) f. Services for children needing long-term ventilation g. Paediatric Critical Care Operational Delivery Network/s The specification for each service should cover: i. Inclusions and exclusions in terms of age and conditions of children for which the service is responsible ii. Interventions to be offered in each PCCU iii. Key performance indicators	N	Commissioners understood the services and visited regularly. Responsibilities and arrangements were not documented. Contract monitoring was in place but no service specification.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PZ-604	**Paediatric Critical Care Operational Delivery Network** Commissioners should agree the catchment population, organisations involved and host organisation for the Paediatric Critical Care Operational Delivery Network/s within the area for which they are responsible.	Y	
PZ-701	**Paediatric Critical Care Quality Monitoring** Commissioners should monitor at least annually key performance indicators and aggregate data on activity and outcomes from each paediatric critical care service, including: **L3 PCCU**: All instances of average occupancy exceeding 85% for more than two successive months **SPTS**: Arrival at referring unit within three hours of the decision to transfer the child	N	Key performance indicators were not yet in place but good working relationships were evident and monitoring was in place.