WM QRS West Midlands Quality Review Service

NHS

Care of Critically Ill & Critically Injured Children in the West Midlands

University Hospital of North Staffordshire NHS Trust

North Staffordshire Combined Healthcare NHS Trust

Visit Date: 30th April 2014 Report Date: August 2014

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INTRODUCTION

This report presents the findings of the review of the care of critically ill and critically injured children which took place on 30th April 2014. The purpose of the visit was to review compliance with West Midlands Quality Review Service (WMQRS) Quality Standards for:

- Care of Critically Ill and Critically Injured Children in the West Midlands, Version 4, March 2013

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 which reviewed the services in North Staffordshire health economy. 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:

- University Hospital of North Staffordshire NHS Trust
- North Staffordshire Combined Healthcare NHS Trust
- NHS North Staffordshire Clinical Commissioning Group
- NHS Stoke on Trent 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 Stoke on Trent Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS was set up as a collaborative venture by 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 North Staffordshire health economy 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.

CARE OF CRITICALLY ILL AND CRITICALLY INJURED CHILDREN

UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

TRUST-WIDE

General Comments and Achievements

The Trust management structure was in a state of change at the time of the review and so the visiting team did not meet a Divisional Medical Director or lead nurse. The Chief Executive was clearly interested and keen to improve the quality of services for children offered by the Trust. Reviewers met only one commissioner who had not had significant involvement with the commissioning of children's services at the Trust.

Immediate Risks: No immediate risks were identified

Concerns

1 **Resuscitation Training**

Nursing staff in all areas, including the high dependency unit, did not have the expected level of training. Reviewers were particularly concerned about surgical and medical high dependency unit because of the level of dependency of children and young people on the unit, including children with epidurals, patient-controlled analgesia and morphine infusions. Evidence of operating department assistants and recovery staff having appropriate resuscitation training was also not available.

Reviewers were told that junior medical staff in the Emergency Department had appropriate levels of resuscitation training but records to confirm this were not available. All paediatric medical staff had appropriate resuscitation training and responded quickly when called from the Emergency Department. Paediatric Intensive Care Unit (PICU) staff would also respond if a child needed resuscitation.

Records of resuscitation training were not easily available and it was not clear how managers in charge of individual departments could know whether their staff had completed appropriate training unless they had separate records (such as happened on PICU). Two resuscitation officers in the Trust ran in-house paediatric basic life support training which had been completed by over 80% staff in paediatric areas. Records for this training was available. Two Resuscitation Council courses were run in the post-graduate medical centre; APLS and PLS (Advanced Paediatric Life Support and Paediatric Life Support). Records of this training were only available if uploaded onto the Trust system. Communication between the staff providing the different types of resuscitation training was not evident.

Some PLS and APLS courses in the months before the review had been cancelled because either instructors or enough candidates were not available. The matron on the paediatric ward was considering organising PLS training because the PLS training of nearly all ward nurses was out of date. Resuscitation scenario training was in place on the paediatric ward.

2 **Accessing the Resuscitation Team**

The arrangements for calling the resuscitation team were of concern for a number of reasons. Staff said that the procedure for calling the paediatric resuscitation team was to ask for 'Group 5'. This would call the paediatric registrar and Foundation Year 2 (FY2) doctor, and the paediatric nurse bleep holder. The paediatric nurse bleep holder may or may not have resuscitation training. The anaesthetist was not routinely part of 'Group 5'. If an anaesthetist was considered necessary, staff would ask separately for an anaesthetist. These arrangements were not documented in the resuscitation policy or clearly displayed in areas where care was being provided for children. In practice, the paediatric wards would also ask PICU staff to attend and PICU staff would support a resuscitation if they were not busy with children on PICU.

3 **Safeguarding Training**

The local policy was that Emergency Department consultants should have level 2 training but local records showed that half of the consultants had level 3 training and the remainder had completed only level 1 training. There was little evidence that children's nurses had completed more than level 1 training, although band 6 and 7 nurses were expected to do level 2 training.

Further Consideration

1 A very good 'Spitfire Stan' feedback form had been developed but had not yet been fully implemented. Reviewers encouraged continuation and embedding of this work. As 'Spitfire Sam' feedback forms are implemented, it may be helpful to display more prominently the results of feedback and the improvements made as a result.

2 Multi-disciplinary arrangements for review and learning may benefit from review. Morbidity and mortality meetings took place in the Emergency Department and, separately, in PICU. Emergency Department consultants were invited to these meetings if they had been involved with the patient. The arrangements for multi-disciplinary review and learning of ward-based care were not clear. It was also not clear whether paediatric anaesthetists were involved in these meetings, even if they had been part of the child's care. Reviewers suggested that multi-disciplinary and multi-departmental review and learning may be helpful so that the whole pathway of care for children and young people could be considered. Plans for an arrangement of this sort were being considered.

3 The possibility of a new relationship with Mid Staffordshire's paediatric services was being discussed at the time of the review. Reviewers commented that active commissioning of services would be needed, including ensuring that standards of care at University Hospital of North Staffordshire NHS Trust were not adversely affected by the changes.

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Children's Emergency Department and Children's Assessment Unit

The paediatric Emergency Department saw 20,000 children per year. A further 13,000 emergency admissions (11,000 medical and 2,000 surgical) were admitted via the Emergency Department of Children's Assessment Unit CAU). The Emergency Department Is a regional trauma centre for adults and children with trauma were stabilised prior to transfer to Birmingham Children's Hospital. The CAU was situated alongside the Emergency Department and provided 24/7 assessments, including consultant opinion if required. The CAU accepted referrals from GPs, midwives and community nurses (hospital at home service). Some families could also access the service directly. The CAU provided eight bed spaces and one resuscitation cubicle.

General Comments and Achievements

Staff in the Emergency Department and Children's Assessment Unit were clearly committed and had thought carefully about how their needs could be met. Children went straight to the children's area of the Emergency Department where the environment was child-friendly with the décor being carefully considered, including in the resuscitation room and the x-ray waiting room. Emergency Department consultants were actively supporting the care of children. Good team working between the Emergency Department and paediatric services was evident, helped by the CAU being located so close to the Emergency Department. A clear, in-house early warning scoring document had been developed, although this had not yet been validated. Good information for parents was available in both the Emergency Department and Children's Assessment Unit.

Good Practice

1 The audit system in the Emergency Department was very well organised. A comprehensive programme was in place with good monitoring of completed audits and systems for ensuring learning from audits had been implemented.

Immediate Risks: No immediate risks were identified.

Concerns

1 Resuscitation training: See Trust-wide section of this report

2 Accessing the resuscitation team: See Trust-wide section of this report

3 Safeguarding training: See Trust-wide section of this report

4 **Nurse training**

No evidence of nursing staff having appropriate competences in care of children with trauma was available.

Further Consideration

1 The pathway for neuroradiology imaging and reporting, especially for children with trauma, may benefit from review. Reviewers were told different versions of this pathway by staff.

2 Relatively little age-appropriate information for children was available.

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IN-PATIENT SERVICE: PAEDIATRIC WARDS 216 & 217, INCLUDING THE HIGH DEPENDENCY UNIT

In-patient paediatric services were provided on two wards, wards 216 and 217. Each ward had 25 beds. Day case surgery (seven beds) and elective in-patient surgery and oncology care was provided on ward 217. Ward 216 was a busy general paediatric ward which included a four bed high dependency care unit. Both wards linked closely with the eight bedded paediatric intensive care unit. Retrieval and transfers of the most seriously ill children was provided in liaison with Birmingham Children's Hospital NHS Foundation Trust though the KIDS paediatric retrieval and transfer service.

General Comments and Achievements

Both paediatric wards were well run with ward 217 having a particularly proactive approach to service improvement. Good arrangements for child safeguarding were in place with good consultant involvement and interest, 24/7 consultant on duty for safeguarding issues and easy access to a very good suite for providing care for children and young people who had been victims of sexual abuse.

Good Practice

1 The environment on the paediatric wards was excellent, including a well organised school room and very good arrangements for ensuring children did not miss out on their education while in hospital. Mobile sensory equipment and a sensory room were available. A good room specifically for young people was available. Other facilities included a well-equipped external play area and parents' room.

2 Consultant paediatricians were on site until 10 pm on weekdays and 6pm at weekends.

3 A good risk assessment for external transfers was in use.

Immediate Risks: No immediate risks were identified.

Concerns

1 Resuscitation training: See Trust-wide section of this report

2 Accessing the resuscitation team: See Trust-wide section of this report

3 Safeguarding training: See Trust-wide section of this report

4 **High dependency training**

The nurse in charge had training in high dependency care but it was not clear that other nurses working on the high dependency unit had appropriate competences for this work. No system of competence assessment or competence records for high dependency care was in use. This issue had, however, been recognised. Nine nurses on ward 216 were booked on a high dependency study day in May 2014 and a rolling programme of nurses attending the High Dependency Unit (HDU) training course had been started.

5 **High Dependency Unit Bedside Checklist**

There was no bed-space checklist covering bedside equipment in the High Dependency Unit. Oxygen and suction were checked but not other equipment.

Further Consideration

1 Nurse staffing on ward 217 appeared low for the number and dependency of the patients on the ward, especially when the geographical spread of the ward is taken into account. The 25 beds on the ward were not, however, fully occupied. No dependency tool was in use or linked to staffing levels. Reviewers were told that the seven nurses on duty could be supplemented by 'bank' nurses if required.

2 The resuscitation equipment checklist did not have space for a signature and date on a daily basis. The arrangements for storing drugs were quite complicated, including a drugs box with two strengths of adrenaline. The policy and arrangements for managing expiry dates was not clear.

3 Reviewers were told by staff from both Trusts of some tensions in the relationships between staff on the in-patient paediatric wards and those at the Darwin Centre. Reviewers suggested that working together to re-establish positive working relationships would be in the best interest of children and young people who needed care from both services.

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PAEDIATRIC ANAESTHESIA

General Comments and Achievements

Designated paediatric lists took place each weekday. The day surgery unit was well organised with a proactive approach to improving service quality, in particular through talking to families about their experiences of care. Criteria for surgery on children were clear and comprehensive. The play specialist was actively involved in the care of children and young people needing day surgery.

Good Practice

1 **Sunday Club:** This was a well-organised time when children needing elective surgery could attend the unit and meet staff. This session was run by the play specialist for children coming for surgery.

2 **Paediatric Anaesthetists:** A paediatric anaesthetic on call rota was in place staffed by anaesthetists with a particular interest in the care of children. Paediatric anaesthetists were also available for advice, support and help during working hours. Reviewers were told that paediatric anaesthetists were very flexible in their response and support for surgeons and other services, including being available to other anaesthetists for advice on the care of children.

Immediate Risks: No immediate risks were identified.

Concerns

1 Resuscitation training: See Trust-wide section of this report

Further Consideration

1 Nurse-led pre-assessment was not yet in place. Reviewers suggested that this could be combined with the Sunday Club in order to reduce the number of hospital visits and help encourage families to attend. It may also be helpful to review whether all families receive the written information about surgery and anaesthesia. A combined Sunday Club and nurse-led pre-assessment may be able to improve the provision of written information to children.

2 The expected contents of the 'grab bag' was not clear and the bag was not checked regularly.

3 Theatres 10 to 23 used a 'holding bay' where for adults and children were kept until they were transferred to an anaesthetic room. This was an unsuitable environment for children. The holding bay was cold and had inadequate lighting. Designated children's bays were available near the entrance but the bay was, in effect, a mixed age and mixed sex area with limited visual separation and no sound separation from adult patients.

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NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (DARWIN CENTRE)

In-patient facilities for children and young people with mental health problems at the Darwin Centre were reviewed with the aim of ensuring these services had appropriate arrangements in the event of a child becoming critically ill. A detailed assessment of compliance with Quality Standards was not undertaken but reviewers visited the unit, viewed facilities and equipment and talked to staff about training and protocols.

General Comments and Achievements

The service had clearly learned a lot from previous reviews of the care of critically ill children and had put considerable effort into ensuring appropriate arrangements were in place. Processes for reducing the risk of harm were robust. The resuscitation equipment bag had a checklist and was checked weekly. Expiry dates were recorded.

Processes for admission, physical examination and liaison with GPs appeared robust.

Immediate Risks: No immediate risks were identified

Concerns: No concerns were identified.

Further consideration

1 Reviewers were told that all staff had appropriate resuscitation training through MAPA. Reviewers considered this may not provide an appropriate level of training and suggested that training to ensure one member of staff on each shift had a higher level of resuscitation training may be appropriate. This would also be in keeping with the other in-patient child and adolescent mental health unit reviewed by WMQRS. All staff were clear that they would ring 999 for an emergency with the physical health of a child.

2 One mask had been expired and had been taken out of the resuscitation equipment but not yet replaced. Arrangements for ensuring equipment and drugs were replaced quickly when required were not clear. Reviewers suggested it may be helpful to remind staff of the importance of having all equipment immediately available when required. The zipped bag did not have a tag or other sealing mechanism. It would therefore be possible for the bag to be opened and equipment taken out and so not be available. Sealing the bag may therefore be helpful.

3 The defibrillator checklist had a space which related to pads and a signature in a column at the bottom. It may be helpful for the form to be clearer about what actually needs to be checked and a space for signing that this check has been done. This would provide a more robust audit trail than the arrangements in place at the time of the review.

4 Reviewers were told by staff from both Trusts of some tensions in the relationships between staff on the in-patient paediatric wards and those at the Darwin Centre. Reviewers suggested that working together to re-establish positive working relationships would be in the best interest of children and young people who needed care from both services.

5 Training records were available but were recorded in pencil with a rubber nearby so that changes could be made. The Trust may wish to consider whether this is a sufficiently robust way of recording training.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Dr Mary Montgomery	Clinical Lead, Kids Intensive Care and Decision Support	Birmingham Children's Hospital NHS Foundation Trust

Visiting Team

Dr Kamljit Kaur	Consultant Paediatric Emergency Medicine	The Royal Wolverhampton NHS Trust
Dana Picken	Modern Matron, Paediatrics	Worcestershire Acute Hospitals NHS Trust
Dr Sue Smith	Consultant Anaesthetist and Divisional Medical Director	The Royal Wolverhampton NHS Trust
Brenda Taylor	A&E Sister	Heart of England NHS Foundation Trust
Caroline Whyte	Paediatric Matron	Walsall Healthcare NHS Trust

Observer

Liz Bagley	Project Manager, Maternity and Children	NHS England

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH 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 varied 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
Care of Critically Ill and Critically Injured Children			
University Hospital of North Staffordshire NHS Trust			
Trust-Wide	9	9	100
Children's Emergency Department	42	32	76
Children's Assessment Unit	35	26	74
In-patient Service: Paediatric Wards including HDU	51	42	82
Paediatric Anaesthesia	16	13	81
Total	**153**	**122**	**80**

Pathway and Service Letters: The Standards are in the following sections:

PC-	Care of Critically Ill Children Pathway	Acute Trust-wide
PM-	Care of Critically Ill Children Pathway	Core Standards for Each Area: Emergency Departments, Children's Assessment Services, In-patient and High Dependency Care Services for Children
PE-	Care of Critically Ill Children Pathway	Emergency Departments Caring for Children
PQ-	Care of Critically Ill Children Pathway	In-patient and High Dependency Care Services for Children
PG-	Care of Critically Ill Children Pathway	Anaesthesia and General Intensive Care for Children

Topic Sections: Each section covers the following topics:

-100	Information and Support for Children and Their Families
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

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TRUST-WIDE

Ref	Quality Standards	Met?	Comments
PC-201	**Board-level lead for children** A Board-level lead for children's services should be identified.	Y	
PC-202	**Lead consultants and lead nurses** The Board level lead for children's services should ensure that the following leads for the care of children have been identified: a. Nominated lead consultants and nurses for each of the areas where children may be critically ill (QS PM-201) b. Nominated lead consultant for emergency and elective surgery in children c. Nominated lead consultant for trauma in children d. Nominated lead anaesthetist (QS PG-201) and lead ICU consultant (QS PG-202) for children	Y	
PC-501	**Minor injuries units** If the Trust's services (QS PC-601) include a Minor Injuries Unit, Walk-in Centre or Urgent Care Centre, this Unit should have a protocol in use in the event of a critically ill child, or potentially critically ill child, presenting. This protocol should include transfer to an appropriate paediatric unit.	N/A	
PC-502	**Hospitals with emergency services 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	N/A	
PC-503	**Hospitals with emergency services for adults only – paediatric advice** Hospitals without on-site assessment or in-patient services for children should have guidelines for accessing paediatric medical advice agreed with a local paediatric medical unit and regularly reviewed.	N/A	
PC-504	**Surgery on children** The Trust should have agreed the exclusion criteria for elective and emergency surgery on children (QS PG-503).	Y	

Ref	Quality Standards	Met?	Comments
PC-601	**Services provided** The Trust should be clear whether it provides the following services and the hospital site or sites on which each service is available: a. Minor Injury Unit, Walk-in Centre or Urgent Care Centre b. Emergency Department for: • Adults • Children c. Trauma service for children and, if so, its designation d. Children's assessment service e. In-patient children's service f. High Dependency Care service for children g. Elective in-patient surgery for children h. Day case surgery for children I. Emergency surgery for children j. Acute pain service for children k. Paediatric Intensive Care retrieval and transfer service l. Paediatric Intensive Care service	Y	
PC-602	**Children's assessment service location** If the Trust provides a children's assessment service, this should be sited alongside either an Emergency Department or an in-patient children's service.	Y	
PC-603	**Hospitals accepting children with trauma** Hospitals accepting children with trauma should also provide, on the same hospital site: a. High Dependency Care service for children b. Paediatric Intensive Care service or a general intensive care unit which admits children needing: • A short period of post-anaesthetic care • Maintenance prior to transfer to PICU (QS PM-506)	Y	
PC-604	**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 Director with responsibility for children's services (QS PC-201). The relationship of the group to the Trust's mechanisms for safeguarding children (QS PM-297) and clinical governance issues relating to children should be clear.	Y	A newly formed group was meeting.

Ref	Quality Standards	Met?	Comments
PC-703	**Approving guidelines and policies** The mechanism for approval of policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should have been agreed by the Trust-wide group (QS PC-604) or a sub-group thereof.	Y	
PC-704	**Child death** The death of a child while in hospital should undergo formal review. This review should be multi-professional and all reasonable steps should be taken to involve specialties who contributed to the child's care. Primary and community services should be involved where appropriate. All deaths of children in hospital should be reported to the local Child Death Overview Panel.	Y	

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CHILDREN'S EMERGENCY DEPARTMENT

Ref	Quality Standards	Met?	Comments
PM-101	**General support for families** The following support services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services Information for parents about these services should also be available.	Y	
PM-102	**Child-friendly environment** There should be a child-friendly environment, including toys and books / magazines for children of all ages. There should be visual and, ideally, sound separation from adult patients.	Y	
PM-103	**Parental access** There should be parental access to the child at all times except when this is not in the interest of the child or the privacy and confidentiality of other children and their families.	Y	
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	Y	Excellent information was available for parents. Some information for children was available but the development of more age-appropriate information may be helpful.

Ref	Quality Standards	Met?	Comments
PM-105	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child.	Y	Excellent parent information was available.
PM-106	**Keeping parents informed** Parents should be informed of the child's condition, care plan and retrieval (if necessary) and this information should be updated regularly.	Y	
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	N	There was no formal policy on financial support. Families were referred to social services for ongoing help if necessary. The service also tried to access additional financial help if required.
PM-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	Y	
PM-201	**Lead consultant and lead nurse** A nominated consultant and nominated senior children's trained nurse should be responsible for: a. Protocols covering the assessment and management of the critically ill child b. Ensuring training of relevant staff The lead consultant and lead nurse should undertake regular clinical work within the area for which they are responsible.	Y	See main report in relation to resuscitation training.
PM-202	**Consultant paediatrician 24 hour cover** 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	
PM-203	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	
PM-204	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site.	Y	

Ref	Quality Standards	Met?	Comments
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	N	See main report.
PM-206	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times.	N	See main report
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency 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. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	N	See main report in relation to resuscitation training. Some trauma training sessions were taking place. A workforce plan for increasing the number of nurses was in place which would help nurses to be able to access training opportunities.
PM-209	**Minimum nurse staffing** Emergency Departments and day surgery services for children should have at least one registered children's nurse on duty at all times in each area. Children's assessment services and in-patient services for children should have at least two registered children's nurses on duty at all times in each area.	Y	

Ref	Quality Standards	Met?	Comments
PM-210	**Nurse with paediatric resuscitation training on duty** At least one nurse with up to date paediatric resuscitation training should be on duty at all times.	N	As QS PM-208
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	Very good support for play was available.
PE-212	**Trauma team** Emergency Departments receiving children with trauma should have a Trauma Team immediately available at all times, including: a. Team Leader (see note 2) b. Emergency Department doctor (senior decision maker) c. Clinician trained to, or training at, the equivalent of paediatric medicine and neonatal medicine (RCPCH) level 2 competences or above (QS PQ-217) d. Clinician with competences in resuscitation, stabilisation and intubation of children (QS PM-203) e. General Surgeon f. Orthopaedic Surgeon	Y	
PE-213	**ED liaison paediatrician** There should be a nominated paediatric consultant responsible for liaison with the nominated Emergency Department consultant (QS PM-201).	Y	
PE-214	**ED sub-speciality trained consultant** Emergency departments seeing 16,000 or more child attendances per year should have an emergency department consultant with sub-specialty training in paediatric emergency medicine and a consultant paediatrician with sub-specialty training in paediatric emergency medicine.	Y	Two Emergency Department consultants had sub-specialty training.
PE-215	**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.	N/A	

Ref	Quality Standards	Met?	Comments
PM-296	**Policy on staff acting outside their area of competence** A Trust policy on staff acting outside their area of competence because this is in the best interest of the child should be in use covering: a. Exceptional circumstances when this may occur b. Staff responsibilities c. Reporting of event as an untoward clinical incident d. Support for staff	N	No policy was available.
PM-297	**Safeguarding training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role b. Be aware who to contact if they have concerns about safeguarding issues and c. Work in accordance with latest national guidance on safeguarding children	N	See Trust-wide section of main report.
PM-301	**Support services 24 hour cover** 24-hour access to pharmacy, biochemistry, pathology, imaging and physiotherapy services able to support the care of children, and weekday access to dietetic services, should be available. 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	Good access to imaging was available with advice and reporting from Alder Hey Hospital. The pathway for neuroradiology imaging and reporting, especially for children with trauma, was less clear and reviewers were told different versions of this pathway by staff.
PE-302	**Critical care support** Emergency Departments accepting children with trauma should have access, on the same hospital site, to: a. High Dependency Care service for children b. Paediatric Intensive Care service or a general intensive care unit which admits children needing: • A short period of post-anaesthetic care • Maintenance prior to transfer to PICU (QS PM-506)	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	The arrangements for checking the defibrillator may benefit from review. It was not clear who was checking the defibrillator. Also, a long roll of checks was kept. Reviewers suggested that this roll should be removed and a shorter record kept.

Ref	Quality Standards	Met?	Comments
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 exceed 30 minutes.	Y	
PM-502	**Paediatric advice** Protocols for accessing advice from the local paediatric service and local paediatric intensive care service should be in use in units where children are not under the care of a paediatrician.	Y	
PM-503	**Clinical guidelines** Guidelines should be in use covering: a. Admission b. Treatment of all major conditions, including meningococcal infection, asthma, status epilepticus, diabetic ketoacidosis, upper airway obstruction and inhaled foreign body. c. Treatment of the consequences of trauma d. Procedural sedation and analgesia e. Discharge	N	Guidelines on the consequences of trauma were not yet available. Regional guidelines were awaited.
PM-504	**Early warning protocol** A protocol designed to provide early warning of deterioration of children should be in use. The protocol should cover observation, monitoring and escalation of care.	Y	A clear in-house protocol was in use although this had not yet been validated.
PM-505	**Resuscitation and stabilisation protocol** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Indications and arrangements for accessing ENT services when needed for airway emergencies c. In Emergency Departments with no on-site children's assessment or in-patient children's service, arrangements for ensuring paediatric medical and appropriate anaesthetic input to the care of the child	N	See main report in relation to alerting the resuscitation team.

Ref	Quality Standards	Met?	Comments
PM-506	**PICU transfer protocol** A protocol on transfer to a PICU should be in use, which should include: a. Accessing advice from a Retrieval Service or PIC consultant and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant with a PIC consultant c. Local guidelines on the maintenance of intensive care for a critically ill child until the child's condition improves or the retrieval team arrives which should stipulate the location/s in which children may be maintained d. Arrangements for the transfer of children requiring specialised intensive care not available in the lead PIC centre, including burns care and ECMO	N/A	
PM-507	**In-hospital transfer protocol** A protocol on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The protocol should specify the escort arrangements and equipment required.	N	No in-house transfer policy was available. A handover document was in use but this did not specify escort arrangements or equipment required.
PM-508	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: 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 The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU.	N/A	
PM-510	**Organ donation policy** A Trust policy on organ donation should be in use which is specific about organ donation in children and includes transplant coordinator contact details.	Y	
PM-511	**Bereavement policy** A Trust bereavement policy should be in use which specifically covers the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems.	Y	

Ref	Quality Standards	Met?	Comments
PE-511	**Trauma protocol** A protocol on care of children with trauma should be in use covering: a. Dedicated phone in the Emergency Department b. Alerting and activating the Trauma Team (QS PE-212) c. Handover from the pre-hospital team to the Trauma Team lead using ATMIST d. Responsibilities of members of the Trauma Team, including responsibility for: i. Liaison with families ii. Calling all relevant consultants e. Involvement of neurosurgeons 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. Other specialist surgery g. Handover of children no longer needing the care of the Trauma Team h. Completing standardised documentation i. Responsibilities for recording receipt of imaging reports j. Major incidents	Y	
PE-512	**Trauma guidelines** Guidelines should be in use covering 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?	Comments
PE-513	**Trauma imaging** A protocol on imaging of children with trauma should be in use which ensures: a. Where indicated, CT is the primary imaging modality b. CT scanning is undertaken within 30 minutes of arrival c. Electronic transmission of images for immediate reporting d. A provisional report is issued within one hour and communicated by telephone and electronically e. Indications and arrangements for review of imaging by a neuro-radiologist f. Full report is issued electronically within 12 hours g. Any significant variations between the provisional and final report are communicated to the senior clinician responsible for the care of the child h. Responsibilities of other services for recording receipt of imaging reports.	Y	See main report in relation to neuroradiology for paediatric trauma (Further Consideration section).
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	Y	A very good audit system was in place.
PM-703	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	Y	Good participation in national audits was evident.
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	See main report.
PM-799	**Document control** All policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should comply with Trust document control procedures.	Y	

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IN-PATIENT SERVICE: PAEDIATRIC WARDS INCLUDING HIGH DEPENDENCY UNIT

Ref	Quality Standards	Met?	Comments
PM-101	**General support for families** The following support services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services Information for parents about these services should also be available.	Y	Information on interpreter services could be more clearly displayed.
PM-102	**Child-friendly environment** There should be a child-friendly environment, including toys and books / magazines for children of all ages. There should be visual and, ideally, sound separation from adult patients.	Y	Services were provided in a high quality, child-friendly environment.
PM-103	**Parental access** There should be parental access to the child at all times except when this is not in the interest of the child or the privacy and confidentiality of other children and their families.	Y	
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	Y	Good information for children and young people was available on ward 217. Similar information was on ward 216 but was not so easily available.
PM-105	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child.	Y	Excellent parent information was available.
PM-106	**Keeping parents informed** Parents should be informed of the child's condition, care plan and retrieval (if necessary) and this information should be updated regularly.	Y	
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	N	There was no formal policy on financial support. Families were referred to social services for ongoing help if necessary. The service also tried to access additional financial help if required.
PQ-108	**Parent information for in-patients** Parents should be given written information about the unit, including visiting arrangements, ward routine and location of facilities within the hospital that the parents may want to use.	Y	Some information was available in the parent's room. It may be helpful to make this information more easily available.

Ref	Quality Standards	Met?	Comments
PQ-109	**Parent facilities for in-patients** Facilities should be available for the parent of each child, including: a. Somewhere to sit away from the ward b. A quiet room for relatives c. A kitchen, toilet and washing area d. A changing area for other young children	Y	
PQ-110	**Overnight facilities** Overnight facilities should be available for the parent or carer of each child, including a foldaway bed or pull-out chair-bed next to the child.	Y	
PQ-111	**Overnight facilities – high dependency care services** Units which provide high dependency care should have appropriate facilities for parents and carers to stay overnight, including accommodation on site but away from the ward.	Y	The PICU relatives' room was used.
PM-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	Y	Ward 217 appeared to have a proactive approach to involving children and families. Undated feedback information was displayed on ward 216 but the ward did not appear as keen on this work and some of the information displayed was adult rather than child-oriented.
PM-201	**Lead consultant and lead nurse** A nominated consultant and nominated senior children's trained nurse should be responsible for: a. Protocols covering the assessment and management of the critically ill child b. Ensuring training of relevant staff The lead consultant and lead nurse should undertake regular clinical work within the area for which they are responsible.	Y	See main report in relation to resuscitation training.
PM-202	**Consultant paediatrician 24 hour cover** 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	
PM-203	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	

Ref	Quality Standards	Met?	Comments
PM-204	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site.	Y	
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	Y	
PM-206	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times.	Y	
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency 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. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	N	Resuscitation scenario training was in place but not individual training and assessment of competence.

Ref	Quality Standards	Met?	Comments
PM-209	**Minimum nurse staffing** Emergency Departments and day surgery services for children should have at least one registered children's nurse on duty at all times in each area. Children's assessment services and in-patient services for children should have at least two registered children's nurses on duty at all times in each area.	Y	See main report in relation to staffing levels on ward 217.
PM-210	**Nurse with paediatric resuscitation training on duty** At least one nurse with up to date paediatric resuscitation training should be on duty at all times.	N	As QS PM-208
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	Very good support for play was available.
PQ-216	**High dependency care: lead consultant and lead nurse** A nominated paediatric consultant and lead nurse should have responsibility for guidelines, policies and procedures (QS PQ-601) and staff competences relating to high dependency care. The consultant should undertake Continuing Professional Development of relevance to high dependency care. The lead nurse should be a senior children's trained nurse with competences and experience in providing high dependency care.	Y	
PQ-217	**Clinician with level 2 competences on duty** A clinician trained to, or training at, the equivalent of paediatric medicine and neonatal medicine (RCPCH) level 2 competences or above should be available on site at all times.	Y	
PQ-218	**High dependency care: nursing competences** Children needing high dependency care should be cared for by a trained children's nurse with paediatric resuscitation training and competences in providing high dependency care.	N	See main report
PQ-219	**High dependency care: nurse staffing** Nurse staffing for children needing high dependency care should be 0.5:1 or 1:1 if nursed in a cubicle. If this is achieved through flexible use of staff (rather than rostering) then achievement of expected staffing levels should have been audited.	Y	
PQ-220	**Tracheostomy care** If children with tracheostomies are cared for on the ward, a healthcare professional with skills in tracheostomy care should be rostered on each shift.	Y	Tracheostomy patients were managed on PICU or with PICU support

Ref	Quality Standards	Met?	Comments
PQ-221	**High dependency care: pharmacy and physiotherapy** Wards providing high dependency care should have pharmacy and physiotherapy staff with appropriate competences and job plan time allocated for their work with children needing high dependency care.	Y	
PM-296	**Policy on staff acting outside their area of competence** A Trust policy on staff acting outside their area of competence because this is in the best interest of the child should be in use covering: a. Exceptional circumstances when this may occur b. Staff responsibilities c. Reporting of event as an untoward clinical incident d. Support for staff	N	No policy was available.
PM-297	**Safeguarding training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role b. Be aware who to contact if they have concerns about safeguarding issues and c. Work in accordance with latest national guidance on safeguarding children	Y	Consultant knowledge of safeguarding was good and appropriate training was in place. A consultant was on duty 24/7 with easy access to a good sexual abuse suite.
PM-301	**Support services 24 hour cover** 24-hour access to pharmacy, biochemistry, pathology, imaging and physiotherapy services able to support the care of children, and weekday access to dietetic services, should be available. 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	
PQ-303	**Other specialties** Access to other appropriate specialties should be available, depending on the usual case mix of patients, for example, 24-hour ENT cover for tracheostomy care.	Y	
PQ-304	**Intensive care support** 24-hour on-site access to a senior nurse with intensive care skills and training should be available.	Y	

Ref	Quality Standards	Met?	Comments
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	The checklist did not have space for a signature and date on a daily basis. The arrangements for storing drugs were quite complicated, including a drugs box with two strengths of adrenaline. Anaesthetic drugs were available from PICU. Ward 216: see Emergency Department comments in relation to defibrillator checks.
PQ-402	**High dependency care: facilities and equipment** An appropriately designed and equipped area for providing high dependency care for children of all ages should be available. Equipment available should be appropriate for the high dependency care and interventions provided (QS PQ-601). Drugs and equipment should be checked in accordance with local policy.	N	There was no bedspace checklist covering bedside equipment. Oxygen and suction equipment were checked.
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 exceed 30 minutes.	N	GP admissions went to CAU rather than to the ward. Some patients, including oncology patients, had open access to the ward. There was no apparent system of initial assessment for these patients.
PM-502	**Paediatric advice** Protocols for accessing advice from the local paediatric service and local paediatric intensive care service should be in use in units where children are not under the care of a paediatrician.	Y	
PM-503	**Clinical guidelines** Guidelines should be in use covering: a. Admission b. Treatment of all major conditions, including meningococcal infection, asthma, status epilepticus, diabetic ketoacidosis, upper airway obstruction and inhaled foreign body. c. Treatment of the consequences of trauma d. Procedural sedation and analgesia e. Discharge	Y	
PM-504	**Early warning protocol** A protocol designed to provide early warning of deterioration of children should be in use. The protocol should cover observation, monitoring and escalation of care.	Y	Very good support for play was available.

Ref	Quality Standards	Met?	Comments
PM-505	**Resuscitation and stabilisation protocol** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Indications and arrangements for accessing ENT services when needed for airway emergencies c. In Emergency Departments with no on-site children's assessment or in-patient children's service, arrangements for ensuring paediatric medical and appropriate anaesthetic input to the care of the child	N	See main report in relation to alerting the resuscition team. The protocol for accessing ENT services when needed was not clear.
PM-506	**PICU transfer protocol** A protocol on transfer to a PICU should be in use, which should include: a. Accessing advice from a Retrieval Service or PIC consultant and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant with a PIC consultant c. Local guidelines on the maintenance of intensive care for a critically ill child until the child's condition improves or the retrieval team arrives which should stipulate the location/s in which children may be maintained d. Arrangements for the transfer of children requiring specialised intensive care not available in the lead PIC centre, including burns care and ECMO.	N/A	
PM-507	**In-hospital transfer protocol** A protocol on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The protocol should specify the escort arrangements and equipment required.	N	No in-house transfer policy was available. A handover document was in use but this did not specify escort arrangements or equipment required.

Ref	Quality Standards	Met?	Comments
PM-508	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: 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 The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU.	N/A	
PM-509	**Transfer contingency protocol** A protocol should be in place for situations where retrieval is clinically inappropriate or time-critical, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies, where retrieval may introduce unsafe delay. The protocol should include: a. Advice from the Retrieval Service or lead PIC centre (QS PM-506) b. Contact details of relevant specialists where additional advice may be required, for example, neurosurgeons c. Escort team of one nurse and one doctor with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the medical escort who would normally be senior clinicians with experience and / or training in a) care of the critically ill child or b) emergency transfer or c) airway management. d. Indemnity for escort team e. Availability of drugs and equipment, checked in accordance with local policy f. Arrangements for emergency transport with a local ambulance service and the air ambulance g. Arrangements for ensuring restraint of children, equipment and staff during transfer	N/A	Time critical transfers were led by PICU.
PM-510	**Organ donation policy** A Trust policy on organ donation should be in use which is specific about organ donation in children and includes transplant coordinator contact details.	Y	

Ref	Quality Standards	Met?	Comments
PM-511	**Bereavement policy** A Trust bereavement policy should be in use which specifically covers the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems.	Y	
PQ-514	**High dependency care: clinical guidelines** Clinical guidelines should be in use covering the provision of high dependency care, including: a. Care of children with: i. Bronchiolitis ii. Status epilepticus iii. Diabetic ketoacidosis iv. Long-term ventilation b. High dependency interventions (QS PQ-601). c. Rehabilitation of children following trauma (if applicable)	Y	Clear guidelines were available and in use.
PQ-601	**High dependency care: operational policy** Wards providing high dependency care should have an operational policy covering: a. Type of children (age and diagnoses) for whom high dependency care will normally be provided b. Expected duration of high dependency care c. High dependency interventions provided, and duration of interventions, including whether the following are provided: i. Invasive monitoring ii. CPAP iii. Renal support d. Expected competences of healthcare staff providing high dependency interventions e. Arrangements for access to paediatric radiology advice f. Arrangements for liaison with lead PICU for advice and support	Y	
PQ-701	**High dependency care: data collection** The paediatric high dependency minimum data set should be collected and submitted to SUS.	Y	
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	Y	
PM-703	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	Y	

Ref	Quality Standards	Met?	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	See main report.
PM-799	**Document control** All policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should comply with Trust document control procedures.	Y	

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Children's Assessment Unit

Ref	Quality Standards	Met?	Comments
PM-101	**General support for families** The following support services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services Information for parents about these services should also be available.	Y	
PM-102	**Child-friendly environment** There should be a child-friendly environment, including toys and books / magazines for children of all ages. There should be visual and, ideally, sound separation from adult patients.	Y	
PM-103	**Parental access** There should be parental access to the child at all times except when this is not in the interest of the child or the privacy and confidentiality of other children and their families.	Y	
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	Y	Excellent information was available for parents. Some information for children was available but the development of more age-appropriate information may be helpful.
PM-105	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child.	Y	Excellent parent information was available.

Ref	Quality Standards	Met?	Comments
PM-106	**Keeping parents informed** Parents should be informed of the child's condition, care plan and retrieval (if necessary) and this information should be updated regularly.	Y	
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	N	There was no formal policy on financial support. Families were referred to social services for ongoing help if necessary. The service also tried to access additional financial help if required.
PM-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	Y	
PM-201	**Lead consultant and lead nurse** A nominated consultant and nominated senior children's trained nurse should be responsible for: a. Protocols covering the assessment and management of the critically ill child b. Ensuring training of relevant staff The lead consultant and lead nurse should undertake regular clinical work within the area for which they are responsible.	Y	See main report in relation to resuscitation training.
PM-202	**Consultant paediatrician 24 hour cover** 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	
PM-203	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	
PM-204	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site.	Y	
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	N	See main report.

Ref	Quality Standards	Met?	Comments
PM-206	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times.	N	See main report.
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency 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. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	N	See main report in relation to resuscitation training.
PM-209	**Minimum nurse staffing** Emergency Departments and day surgery services for children should have at least one registered children's nurse on duty at all times in each area. Children's assessment services and in-patient services for children should have at least two registered children's nurses on duty at all times in each area.	Y	
PM-210	**Nurse with paediatric resuscitation training on duty** At least one nurse with up to date paediatric resuscitation training should be on duty at all times.	N	As QS PM-208

Ref	Quality Standards	Met?	Comments
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	Very good support for play was available.
PM-296	**Policy on staff acting outside their area of competence** A Trust policy on staff acting outside their area of competence because this is in the best interest of the child should be in use covering: a. Exceptional circumstances when this may occur b. Staff responsibilities c. Reporting of event as an untoward clinical incident d. Support for staff	N	No policy was available.
PM-297	**Safeguarding training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role b. Be aware who to contact if they have concerns about safeguarding issues and c. Work in accordance with latest national guidance on safeguarding children	N	See Trust-wide section of main report.
PM-301	**Support services 24 hour cover** 24-hour access to pharmacy, biochemistry, pathology, imaging and physiotherapy services able to support the care of children, and weekday access to dietetic services, should be available. 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	
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 exceed 30 minutes.	Y	
PM-502	**Paediatric advice** Protocols for accessing advice from the local paediatric service and local paediatric intensive care service should be in use in units where children are not under the care of a paediatrician.	Y	

Ref	Quality Standards	Met?	Comments
PM-503	**Clinical guidelines** Guidelines should be in use covering: a. Admission b. Treatment of all major conditions, including meningococcal infection, asthma, status epilepticus, diabetic ketoacidosis, upper airway obstruction and inhaled foreign body. c. Treatment of the consequences of trauma d. Procedural sedation and analgesia e. Discharge	Y	
PM-504	**Early warning protocol** A protocol designed to provide early warning of deterioration of children should be in use. The protocol should cover observation, monitoring and escalation of care.	Y	A clear in-house protocol was in use although this had not yet been validated.
PM-505	**Resuscitation and stabilisation protocol** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Indications and arrangements for accessing ENT services when needed for airway emergencies c. In Emergency Departments with no on-site children's assessment or in-patient children's service, arrangements for ensuring paediatric medical and appropriate anaesthetic input to the care of the child	N	See main report in relation to alerting the resuscitation team.
PM-506	**PICU transfer protocol** A protocol on transfer to a PICU should be in use, which should include: a. Accessing advice from a Retrieval Service or PIC consultant and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant with a PIC consultant c. Local guidelines on the maintenance of intensive care for a critically ill child until the child's condition improves or the retrieval team arrives which should stipulate the location/s in which children may be maintained d. Arrangements for the transfer of children requiring specialised intensive care not available in the lead PIC centre, including burns care and ECMO.	N/A	

Ref	Quality Standards	Met?	Comments
PM-507	**In-hospital transfer protocol** A protocol on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The protocol should specify the escort arrangements and equipment required.	N	No in-house transfer policy was available. A handover document was in use but this did not specify escort arrangements or equipment required.
PM-508	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: 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 The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU.	N/A	
PM-510	**Organ donation policy** A Trust policy on organ donation should be in use which is specific about organ donation in children and includes transplant coordinator contact details.	Y	
PM-511	**Bereavement policy** A Trust bereavement policy should be in use which specifically covers the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems.	Y	
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	Y	A very good audit system was in place.
PM-703	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	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	See main report.

Ref	Quality Standards	Met?	Comments
PM-799	**Document control** All policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should comply with Trust document control procedures.	Y	

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PAEDIATRIC ANAESTHESIA

Ref	Quality Standards	Met?	Reviewer Comment
[PC-601]	**Surgery and anaesthetic services** The Trust should be clear whether it provides the following services for children and the hospital site or sites on which each service is available: a. Elective in-patient surgery for children b. Day case surgery for children c. Emergency surgery for children d. Acute pain service for children	Y	
PG-102	**Information on anaesthesia** Age-appropriate information about anaesthesia should be available for children and families.	Y	
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	Y	
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	**GICU lead consultant** A nominated lead intensive care consultant should be responsible for Intensive Care Unit policies and procedures relating to children.	N/A	
PG-203	**Lead nurse** A nominated lead nurse should be responsible for ensuring policies, procedures and nurse training relating to children admitted to the general intensive care unit are in place.	N/A	

Ref	Quality Standards	Met?	Reviewer Comment
PG-204	**Medical staff caring for children** All anaesthetists or intensivists with emergency and / or elective paediatric responsibility should have up to date knowledge of advanced paediatric life support / resuscitation and stabilisation of critically ill children.	Y	Paediatric intensivists had regular involvement with the care of critically ill children. Evidence of compliance for anaesthetists was available.
PG-205	**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	
PG-206	**Operating department assistance** Operating department assistance from personnel trained and familiar with paediatric work 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	See main report in relation to resuscitation training.
PG-207	**Recovery staff** At least one member of the recovery room staff who has training and experience in paediatric practice should be available for all elective children's lists.	N	See main report in relation to resuscitation training.
PG-401	**Induction and recovery areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	Y	See main report in relation to holding bay.
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	Arrangements for the care of children and young people needing day surgery were well organised.
PG-403	**Drugs and equipment** Appropriate drugs and equipment should be available in each area in which paediatric anaesthesia is delivered. Drugs and equipment should be checked in accordance with local policy.	Y	The resuscitation trolley had appropriate equipment and was checked regularly. A 'grab bag' was also available on Ward 217. It was not clear what equipment was expected to be in this bag or how it was checked.

Ref	Quality Standards	Met?	Reviewer Comment
PG-404	**GICU paediatric area** The general intensive care unit should have an appropriately designed and equipped area for providing intensive 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.	N/A	
PG-501	**Role of anaesthetic service in care of critically ill children** Protocols for resuscitation, stabilisation, accessing advice, transfer and maintenance of critically ill children (QSs PM-503 to PM-509) and the provision of high dependency care (QS PQ-514 and PQ-601) should be clear about the role of the anaesthetic service and (general) intensive care in each stage of the child's care.	Y	The arrangements for internal transfers could be clearer. A handover document was available but this did not cover internal transfers, such as to imaging. Much of the documentation said that PICU should be contacted if difficulties arose.
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. A children's nurse is available to support the care of the child and should review the child at least every 12 hours c. There should be discussion with a PICU about the child's condition prior to admission and regularly during their stay on the general intensive care unit d. A local paediatrician should agree to the child being moved to the intensive care unit and should be available for advice e. A senior member of the paediatric team should review the child at least every 12 hours during their stay on the general intensive care unit	N/A	
PG-503	**Surgery criteria** Protocols should be in use covering: a. Exclusion criteria for elective and emergency surgery on children b. Day case criteria c. Non-surgical procedures requiring anaesthesia	Y	Surgery criteria were clear and comprehensive.

Ref	Quality Standards	Met?	Reviewer Comment
PG-504	**Clinical guidelines - anaesthesia** Clinical guidelines should be in use covering: a. Analgesia for children b. Pre-operative assessment c. Preparation of all children undergoing general anaesthesia	N	Pre-operative assessment guidelines were in development.
PG-601	**Liaison with theatre manager** There should be close liaison between the lead consultant/s for paediatric anaesthesia (QS PG-201) and the Theatre Manager with regard to the training and mentoring of support staff.	Y	
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	**High dependency care: data collection (GICU)** The paediatric high dependency minimum data set should be collected and submitted to SUS.	N/A	

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