WM QRS West Midlands Quality Review Service

NHS

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

Birmingham Children's Hospital NHS Foundation Trust

Visit Date: 11th & 12th June 2014 Report Date: August 2014

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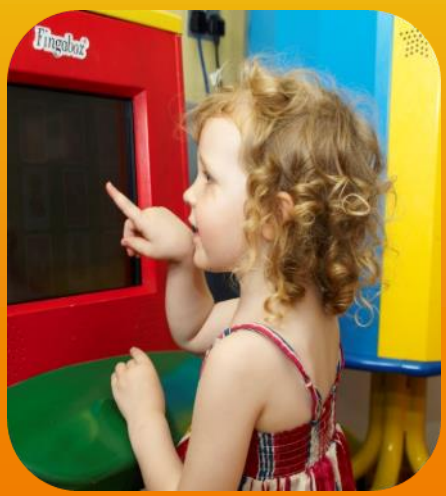

INDEX

Introduction **3**

Care of Critically Ill and Critically Injured Children **4**

Trust-Wide 4

Emergency Department (Including Clinical Decisions Unit and Observation Unit) 6

In-Patient – Surgical (Including Neonatal Surgery, Ward 5, Ward 9 and Day Surgery Unit) 7

In-Patient – Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Ward 2, Ward 7 and Wellcome Unit) 7

Paediatric Anaesthesia 7

Parkview Child and Adolescent Mental Health Service 8

Imaging Service 8

Appendix 1 Membership of Visiting Team **9**

Appendix 2 Compliance with Quality Standards **10**

INTRODUCTION

This report presents the findings of the review of the Care of Critically Ill and Critically Injured Children which took place on 11th and 12th June 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 at Birmingham Children's Hospital NHS Foundation 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:

- Birmingham Children's Hospital NHS Foundation Trust
- NHS Birmingham South Central 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 Birmingham South Central 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 Birmingham Children's Hospital NHS Foundation Trust 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.

Return to *Index*

CARE OF CRITICALLY ILL AND CRITICALLY INJURED CHILDREN

TRUST-WIDE

This review looked at the care of critically ill and critically injured children across Birmingham Children's Hospital NHS Foundation Trust and, in particular:

- Emergency Department (including Clinical Decisions Unit and Observation Unit)
- In-Patient – Surgical (including Neonatal Surgery, Ward 5, Ward 9 and Day Surgery Unit). This part of the review included consideration of post-surgery discharge arrangements
- In-Patient – Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Ward 2, Ward 7 and Wellcome Unit)
- Paediatric Anaesthesia
- Parkview Child and Adolescent Mental Health Service
- Imaging

General Comments and Achievements

Reviewers were impressed by the welcoming and open culture evident at Birmingham Children's Hospital NHS Foundation Trust. Significant changes in culture, attitude and service organisation had taken place and this was particularly noticeable by reviewers who had taken part in previous peer review visits to the Trust. A commitment to listening to and learning from children and young people, families and staff was evident throughout the review. The Trust was also clearly placing emphasis on the introduction of robust processes and a systematic approach to achieving appropriate standards. Examples of changes made included improved staffing of several services, the introduction of a centralised audit and risk management database, improvements to equipment and facilities, active management and monitoring or tertiary admissions, e-rostering, development of a child-specific safety thermometer and the introduction of a Hospital Operations Centre. Innovations, including new ways of working and new roles, were being actively encouraged.

The Trust chose to present all evidence for this review electronically. This approach worked well and reduced the impact of the review on clinical time.

Good Practice

1 The Paediatric Assessment Clinical Intervention and Education team (PACE) provided practical support 24/7 for the sickest patients and education for staff. Reviewers saw the team in action during the course of the visit and were impressed by the work of the team in improving care for very sick children.

2 The Trust had a very flexible approach to use of staff across its wards and Emergency Department. The Hospital Operations Centre had an important role in achieving this. Relevant people came together at least twice daily to review bed occupancy, dependency and expected admissions. Staff were then allocated according to the need in each area. If patients were waiting more than 24 hours for discharge then a more senior manager became involved. Contingency plans for managing fluctuations in capacity were in place, including use of PACE and the PICU (Paediatric Intensive Care Unit) Technical Team. All staff were very positive about the impact these processes had had on improving the flow of patients through the hospital.

3 Ward nursing staff were all defined as 'expert', 'competent' or 'novice'. The competences for each role were clearly defined and linked to the e-rostering system. This system meant that staff with appropriate competences were on duty at all times. It also helped with the flexibility of staffing and movement of staff between wards and departments.

4 Support for parents and families was excellent, including good written information for children, young people and families, credit card-sized phone number cards and verbal support including, for example, telephoning to reassure parents at night who had to be at home with siblings.

5 Educational support, the school room and support for play were also well-organised, sensitive to the needs of children and young people and proactive in their contribution to the therapeutic process.

Immediate Risks: No immediate risks were identified

Concerns

1 **In-patient ward facilities**

Facilities on the in-patient wards reviewed were cramped and not adequate for their purpose. In particular, the amount of room around beds was insufficient. Reviewers considered that this increased the risk of infection because beds were so close together, in an emergency would make it difficult for the team to reach the child, and reduced privacy. Ward 2 had particularly limited space but the medical High Dependency Unit was small and surgical wards were cramped. The Trust was aware of this problem and was developing short and longer-term plans to improve the situation.

2 **Document control**

Some policies and guidelines were out of date, for example, the in-hospital transfer policy was due for review in June 2013 and the resuscitation policy was two months out of date (although both were under review at the time of the visit). Clinical guidelines for infantile spasm were out of date and included an inappropriate first line treatment, although reviewers considered that junior staff may not be using these guidelines. Bronchiolitis guidelines were also out of date. The Trust was aware of this problem and was planning to introduce a new document management system.

Further Consideration

1 White-boards with patient-identifiable information were clearly visible in the Emergency Department and wards. This helped staff communication but meant that patient confidentiality was not guaranteed and families could easily know what was happening to other children. Reviewers suggested that consideration should be given to ways of improving the confidentiality of information on the white boards.

2 Reviewers commented on two aspects of the management of resuscitation equipment. One of the seven resuscitation trolleys in theatres was not sealed whereas all other trolleys were sealed. It had been appropriately checked but reviewers queried why it was different from the other trolleys. Also, defibrillators on wards 5 and 9 were checked appropriately but there were two checklists and, on some occasions, only one had been completed. Reviewers suggested simplifying the system of defibrillator checking so that only one checklist needed to be completed. Although found in specific areas, these points may apply more generally across the Trust.

3 Pre-admission pre-operative assessment was not consistently implemented across surgical specialties. Good play specialist support was available for children with specific problems but this was not available for all children. Reviewers suggested that wider and more consistent use of pre-admission pre-operative assessment may help to reduce length of stay and improve patient and family experience.

4 Reviewers were impressed by PACE (see good practice section above) and made some suggestions about its future development:

a. The criteria for involving PACE were not entirely clear. This had been a definite decision while the service was under development. Reviewers commented that this could result in the team becoming a ‘victim of its own success’. Also, some patients were seen but not ‘taken on by PACE’. The criteria for this decision were also not clear and it may be helpful if they were defined.

b. Management responsibility for the team was being considered at the time of the review. The PACE team commented that the arrangement of rotating staff with the hospital at night team worked well as it gave staff a range of experience.

c. The PACE service specification was not yet finalised, despite the service having been in operation for about 18 months. Reviewers suggested that finalising the service specification would be helpful.

5 Although the Hospital Operations Centre had improved the management of bed capacity, capacity pressures were still present and clearly evident on the day of the review. As a result cancellations and delays in elective surgery were taking place. The Trust had started work on improving discharge planning and was trying hard not to transfer patients out of the hospital inappropriately. The patient pathway appeared good for patients admitted as emergencies who were discharged quickly. After 30 days length of stay a weekly 'what does the patient need?' meeting involving more senior managers actively managed the discharge process. Reviewers were given feedback from multiple sources that patient flow was not as good for patients with lengths of stay of between three and 30 days. Speeding up the discharge of this group of patients may help to address capacity problems.

6 Each high dependency area had a separate operational policy which varied in what they covered. Reviewers suggested that a common core high dependency operational policy with additional sections for the specialist areas may be helpful.

7 Reviewers were impressed by the range of systems for feedback from children, young people, families and staff and suggested that feedback arrangements could be further improved by systems for regular feedback from clinicians in referring hospitals. Areas which may benefit from discussion include a) communication about patients waiting in beds in other Trusts for admission to Birmingham Children's Hospital and offering consultant review and advice during this period, and b) speed of communication with other Trusts when children are discharged home or seen in clinic.

Return to *Index*

Emergency Department (Including Clinical Decisions Unit and Observation Unit)

General Comments and Achievements

The environment in the new Emergency Department was colourful, bright and child-friendly. It was clear that considerable thought and care had gone into the design of the Department and the facilities within it. Reviewers visited the Department at a very busy time but, despite this, the Department was calm, children appeared comfortable and the workload was well-managed. Staff were open and welcoming. The level of medical staffing was relatively good which gave staffing flexibility in order to respond to problems.

Good Practice

1 Processes for resuscitation of children and management of trauma were robust. Roles were clear and good teamwork between departments was evident.

2 The audit system was well-organised. Audits were well-documented and this documentation was available for everyone in the hospital to see. A good range of audits was undertaken.

3 Staff in the Emergency Department had a very high level of advanced paediatric resuscitation training. All nurses of band 6 and above had APLS (Advanced Paediatric Life Support) training as did all consultants and middle-grade doctors.

4 Written information for parents was clear, well-written and easily accessible. The Trust also had plans to introduce Medikidz comic strips books for young people.

5 See also Trust-wide section of this report.

Immediate Risks: No immediate risks were identified

Concerns: No concerns were identified

Further Consideration: See Trust-wide section of this report.

Return to *Index*

In-Patient – Surgical (Including Neonatal Surgery, Ward 5, Ward 9 and Day Surgery Unit)

In-Patient – Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Ward 2, Ward 7 and Wellcome Unit)

General Comments and Achievements

The environment on all the wards visited was age-appropriate with child-focussed team-working clearly apparent in each ward. Wards were welcoming and all the parents who met reviewers were happy with the communication they received about their child's care. Reviewers were particularly impressed with the work of the ward-based play facilitators and Play Specialist Team. These staff had a clear role in the care of children and young people and had good plans for the further development of the service. Escalation policies and pathways covering when capacity was under pressure were clear and well-understood by staff.

Progress had been made on the development of post-surgery discharge arrangements. Patients were given 'cards' explaining who to ring if they had concerns, good patient information was available, each ward kept a telephone log of post-discharge contacts and advice given and this was also covered in nursing documentation.

Good Practice: See Trust-wide section of this report

Immediate Risks: No immediate risks were identified

Concerns: See Trust-wide section of this report.

Further Consideration

1 Awareness of arrangements for access to play services in the Wellcome Unit may benefit from review. Some staff told reviewers that access to play support was not available to the Wellcome Unit whereas other staff said that the Unit had a 0.5 w.t.e. play specialist and the Unit could book additional support if required.

Return to *Index*

Paediatric Anaesthesia

General Comments and Achievements

Paediatric anaesthesia services at Birmingham Children's Hospital were well-organised and reviewers were particularly impressed by the good support provided by senior staff to more junior colleagues.

Good Practice

1 Engagement of theatre staff in the running and improvement of the service was good. Over 50% theatre staff had responded to a staff questionnaire and over 95% of these were satisfied with their working arrangements.

2 The theatre dashboard had very clear information about all theatres and activity levels. This was a live system, including identifying which staff were working in which theatre.

Immediate Risks: No immediate risks were identified

Concerns: No concerns was identified

Further Consideration

1 See Trust-wide section of this report in relation to pre-admission pre-operative assessment (further consideration 3).

2 See Trust-wide section of this report in relation to resuscitation equipment (further consideration 2).

Return to *Index*

PARKVIEW CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

General Comments and Achievements

Reviewers visited the Parkview Child and Adolescent Mental Health Service, looked at relevant policies and talked to a range of staff about the arrangements should a child become critically ill. Staff had basic life support training and called an ambulance if the needs exceeded their level of competence. The arrival point for the ambulance was clear. Each ward had a 'grab bag' of drugs and equipment should a transfer be needed. The Trust-wide paediatric early warning score (PEWS) was in use and work to refine this for the population of children with mental health-related needs was underway. Staff were also actively working to reduce risks, including risks of self-harm. All policies and protocols relating to the care of critically ill and critically injured children were available and appropriate, including rapid tranquillisation.

Concerns: No concerns were identified.

Further Consideration

1 Levels of basic life support training of staff had been running at nearly 100% until January 2014. Since then levels had fallen to 70 to 75%. It will be important to ensure that resuscitation training levels are improved.

2 Previous peer review visits to Parkview had recommended the establishment of links with a local general practice for the general medical care of children and young people who are in-patients. It was not clear that such arrangements had been put in place.

Return to *Index*

IMAGING SERVICE

General Comments and Achievements

New management arrangements for the imaging service had been introduced and managers were keen to take forward the development of the department. Staff in the imaging service had basic life support training and rang 222 if additional support was needed. A day case nurse accompanied children who needed scans under sedation.

Further Consideration

1 The waiting area was child-friendly but other areas within the department were quite bare and clinical. Reviewers suggested that the environment could be made child-friendly relatively easily.

Return to *Index*

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Executive Lead

Dr John Alexander	Clinical Director, PICU	University Hospital of North Staffordshire NHS Trust

Visiting Team

Dr Penny Dison	Consultant Paediatrician	The Royal Wolverhampton NHS Trust
Dr Vincent Bulso	Consultant in Anaesthesia and Critical Care Medicine / Clinical Director of Critical Care	Sandwell & West Birmingham Hospitals NHS Trust
Elaine Day	Patient Representative	
Helen Cope	Lead Resuscitation Officer	Sandwell & West Birmingham Hospitals NHS Trust
Paul Duflot	Ward Manager	Sandwell & West Birmingham Hospitals NHS Trust
Dr Kamljit Kaur	Consultant Paediatric Emergency Medicine	The Royal Wolverhampton NHS Trust
Mr Nigel Kiely	Consultant Orthopaedic Surgeon	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Paula Lane	Lead Nurse, Paediatric Emergency Department	Heart of England NHS Foundation Trust
Dana Picken	Modern Matron, Paediatrics	Worcestershire Acute Hospitals NHS Trust

Observers

John James	Chief Executive	Sickle Cell Society
Cath Quilliam	Head of Community Health Services	Isle of Man Department of Health and Social Care

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service

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			
Trust-wide	10	10	100
Emergency Department (including Clinical Decisions Unit and Observation Unit)	41	39	95
In-patient: Surgical (including Neonatal Surgery, Ward 5, Ward 9 and Day Surgery Unit) In-patient: Medical (including Paediatric Assessment Unit, Medical High Dependency Unit, Ward 2, Ward 7 and Wellcome Unit)	53	49	92
Paediatric Anaesthesia	16	16	100
Total	**120**	**114**	**95**

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

Return to *Index*

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.	Y	
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	

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	

Return to *Index*

Emergency Department (including Clinical Decisions Unit and Observation 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	The environment in the Emergency Department was very child-friendly.
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	
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	

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-107	**Information for parents of children needing transfer** Parents of children needing emergency transfer should be given all possible help regarding transport, hospital location, car parking and location of the unit to which their child is being transferred.	Y	This information was provided by KIDS (Kids Intensive Care and Decision Support) retrieval and transfer service.
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	Y	Relevant information was available.
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	
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.	Y	

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.	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	Y	
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	Good contingency plans were in place.
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.	Y	
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	

Ref	Quality Standards	Met?	Comments
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.	N/A	
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	
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/A	
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	

Ref	Quality Standards	Met?	Comments
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	
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	
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	Clear streaming of patients was in place.
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.	N/A	
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	Very good guidelines were in use.

Ref	Quality Standards	Met?	Comments
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	
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	Y	
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.	Y	This protocol was due for review in June 2013.

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.	Y	This protocol was due for review in June 2013.
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	
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.	N	A national document was available but there was no local policy. A PICU policy was available but out of date.

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	
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	
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	
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 strong commitment to learning from feedback was evident.
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.	N	See main report (Trust-wide concern 2).

Return to *Index*

IN-PATIENT

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		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	A good range of information was available. Each ward had interesting displays about celebration days for different faiths.
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	Parents who met the visiting team said that staff encouraged them to be with their children and were also sensitive to when they needed a break from this.
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	Y	
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	A lot of information for parents was available. The Trust was also in the process of standardising patient information and ward booklets for parents of in-patients.
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	Parents who met the visiting team had been kept well-informed.
PM-107	**Information for parents of children needing transfer** Parents of children needing emergency transfer should be given all possible help regarding transport, hospital location, car parking and location of the unit to which their child is being transferred.	N/A	

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	Y	Relevant information was available.
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	Very good information was available.
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	Parents of children on the surgical day unit shared the staff kitchen but were not usually in the unit for more than a few hours.
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	Excellent overnight facilities were available. Parents commented that staff were very good at recognising when they did not want to stay by their child. Facilities on ward 9 were about to be refurbished.
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	
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	Comprehensive feedback arrangements were in place, including a feedback 'app'. The Trust was clearly committed to learning from feedback, including 'you said - we did' displays.
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	

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
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.	Y	Three RMOs (Resident Medical Officers) on the Hospital at Night rota only had PILS (Paediatric Immediate Life Support). RMO2 was the default team leader for cardiac arrests but someone from PICU, PACE and the RMO registrar would have appropriate training.
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	As QS PM-205.
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	

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
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	Y	
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.	Y	
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	Awareness of play support to the Wellcome Unit may benefit from review.
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	

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
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.	Y	A good training package for Band 4 staff was also available.
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	
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/A	

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
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	Approximately 75% to 80% of ward staff had completed level 2 training. Level 1 training had higher compliance levels. It will be important to ensure that level 2 training levels do not drop further.
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	
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	See main report (Trust-wide further consideration 2) in relation to de-fibrillator 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.	Y	Ward 9 was in need of refurbishment. Ward 5 high dependency facilities were good. Ward 2 was very cramped and the Medical HDU was small.

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		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.	N/A	
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	Some of the policies and guidelines were out of date or had no review date (see Trust-wide concern 2).
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	
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	Y	The resuscitation protocol was being revised at the time of the review.

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		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.	Y	This protocol was due for review in June 2013.
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.	Y	This protocol was due for review in June 2013.

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
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	
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.	N	A national document was available but there was no local policy. A PICU policy was available but out of date.
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	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
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	
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	See main report (Trust-wide further consideration 7).
PQ-701	**High dependency care: data collection** The paediatric high dependency minimum data set should be collected and submitted to SUS.	N	Data on high dependency care provided on wards were not submitted to SUS.
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	A Trust--wide overview was being developed.

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		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	
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.	N	See main report (Trust-wide concern 2).

Return to *Index*

IN-PATIENT: ADDITIONAL SURGERY-SPECIFIC QUALITY STANDARDS

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
-1	**Post-Surgery Discharge Information and Support** Before discharge, each child or young person who has undergone surgery and their family should be offered written information on: a. Their condition (unless this information has been given previously) b. Surgery undertaken and potential complications c. Care and activities after discharge, especially wound care and pain relief d. Early warning signs of problems and what to do if these occur e. Who to contact for advice and their contact details f. Planned review date and how to access a review more quickly, if necessary This information should also be communicated to the young person's general practitioner.	Y	Parents and their GP were given a card with contact numbers showing who to phone.

Ref	Quality Standards	Surgical (Incl. Neonatal Surgery, Wards 5 & 9, Day Surgery) Medical (Paediatric Assessment Unit, Medical High Dependency Unit, Wards 2 & 7, Wellcome Unit)	
		Met?	Comments
-5	**Post-Surgery Discharge - 24/7 Advice Guidelines** If arrangements for 24/7 advice for children and young people who have undergone surgery and their families involve paediatric ward staff then guidelines should be in use covering advice to be given, and indications for contacting the relevant surgical team.	Y	Guidelines were available on the telephone log. Relevant information was also recorded on the nursing discharge documentation, the in-patient leaflet and the card given to families.
-6	**Ward Operational Policy** The ward operational policy should cover: a. Arrangements for 24/7 post-discharge advice for children and young people who have undergone surgery and their families.	N	Standard Operating Procedures on wards 5 and 10 did not include arrangements for giving post-surgery advice.

Return to *Index*

PAEDIATRIC ANAESTHESIA

Ref	Quality Standards	Met?	Comments
[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	Very good information for children was available.
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	Excellent feedback opportunities were available and the Trust appeared very open to feedback.
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	

Ref	Quality Standards	Met?	Comments
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	
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	Medical staff all had appropriate experience and competences were kept up to date through their regular work.
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.	Y	
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.	Y	
PG-401	**Induction and recovery areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	Y	All areas were child friendly. Children could follow a specific colour on the walls to find the theatre they were going to.
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	Children admitted for a dressing change would be admitted to a specialist area for burns and not the day surgery unit and children requiring surgery would go to the day surgery unit.

Ref	Quality Standards	Met?	Comments
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	
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 resuscitation policy was out of date (March 14).
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	

Ref	Quality Standards	Met?	Comments
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	
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	Y	
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	There was good feedback to and from the staff with good levels of satisfaction expressed.
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	

Return to *Index*