WM QRS West Midlands Quality Review Service

NHS

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

South Warwickshire NHS Foundation Trust

Visit Date: 21st October 2014

Report Date: January 2015

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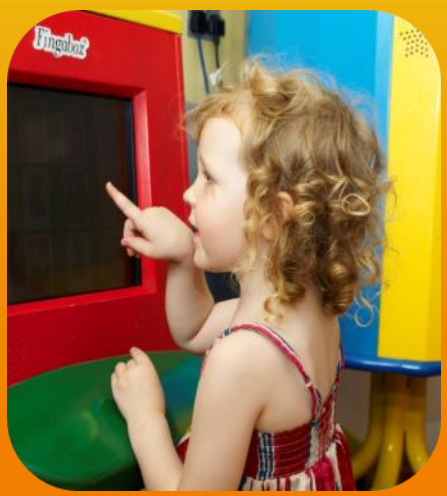

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INTRODUCTION

This report presents the findings of the review of the care of critically ill and critically injured children that took place on 21st October 2014. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Care of Critically Ill and Critically Injured Children in the West Midlands, Version 4.2, December 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 South Warwickshire 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:

- South Warwickshire NHS Foundation Trust
- NHS South Warwickshire 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 South Warwickshire 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 South Warwickshire 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.

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CARE OF CRITICALLY ILL & CRITICALLY INJURED CHILDREN

ACUTE TRUST-WIDE

General Comments and Achievements

South Warwickshire NHS Foundation Trust provided Emergency Department, in-patient paediatric and day surgery services to a population of approximately 45,000 children.

Overall, reviewers found good team-working within and between departments with a strong commitment to working together to provide high quality care for children. A good Trust-wide group was in place to address issues relating to the care of critically ill children with membership which included Emergency Department, paediatric, anaesthetic and surgical staff. Reviewers also commented that the evidence of compliance with Quality Standards was clearly presented and reflected what was happening in practice.

Good Practice

1 The Trust Resuscitation Officer provided very good support to front-line services. Regular updates were offered which helped staff to maintain competences between the four yearly training. All staff were notified three months before their resuscitation training was due to expire. Checking of trolleys was audited regularly and information on compliance was shared across services.

2 The Trust had an innovative approach to the recruitment of children's trained nurses with a rotation planned involving community, Emergency Department and ward placements. Reviewers considered this would be attractive to newly qualified nurses. The Trust had received more applicants than posts and so was considering over-recruiting.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Checking of Resuscitation Trolleys**

Arrangements for checking resuscitation trolleys and theatre trolleys were reinforced during the course of the review visit. Robust implementation on an ongoing basis will be needed to ensure appropriate drugs and equipment are always available when needed for a resuscitation.

2 **Transfer protocols**

Protocols for in-hospital transfer and for transfer of children and young people needing high dependency care were not yet in place. High dependency transfers were undertaken by KIDS (Kids Intensive Care and Decision Support) when available but transfer by South Warwickshire staff were occasionally required.

Further Consideration

1 Reviewers suggested that consideration be given to the Resuscitation Officer taking responsibility for trolleys in theatres to ensure consistency of arrangements.

2 Sealing resuscitation trolleys may save time on checking and avoid the possibility of drugs or equipment being 'borrowed'. This could be combined with innovative arrangements for ensuring staff remain familiar with the contents and layout of trolleys.

3 The Trust used Paediatric Early Warning Scores (PEWS) which ranged from one to five. It may be helpful to consider a scoring system with greater discrimination. During the course of the visit staff were reminded of the need to quote clinical parameters and not PEWS scores during communication with other units and services.

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Emergency Department

General Comments and Achievements

Staff in the Emergency Department were working hard to meet the needs of children. The Emergency Department had separate waiting, assessment and treatment areas for children. The Trust recognised that the environment was in need of updating. All paediatric guidelines were shared across the Trust. Working relationships with paediatric services were good and mutually supportive.

Good Practice

1 An Emergency Nurse Practitioner-led 'see and treat' model had been implemented for children as well as adults. As a result, children were usually seen very quickly.

Immediate Risks: No immediate risks were identified.

Concerns

1 A high proportion of front-line staff had level 2 safeguarding training. Relatively few staff had level 3 training. All middle grade doctors had completed level 3 training but not the ENPs running the 'see and treat' service. Weekly two hour level 2 training updates were available so that staff could maintain their level 2 training. This mapped to Trust mandatory training requirements. Few front-line staff had level 3 safeguarding.

2 At the time of the review the Department did not have enough registered sick children's nurses to ensure one on each shift. Active recruitment was in progress (see 'Good Practice' in the Trust-wide section of this report) which would address this issue.

Further Consideration

1 Although the 'see and treat' service worked very well if the Department was not busy, children could wait for up to 20 minutes before being seen. (If waiting times exceeded 20 minutes then an Emergency Department nurse saw the child.) The list of conditions which should not go to the 'see and treat' area was adult-orientated and reviewers suggested that a separate paediatric list should be developed, including 'high fever' and 'parental concern' to avoid the possibility of a child's condition deteriorating while waiting to be seen.

2 Refurbishment of paediatric area to make it more child-friendly was being considered. Reviewers suggested that, as part of this work, it may be helpful to provide facilities for monitoring children within the paediatric area. At the time of the review children had to go to the resuscitation area if they needed monitoring.

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In-Patient Care

General Comments and Achievements

Paediatric services were provided by a well-organised team. Seven consultants, with two locums at the time of the review, ran a 1:6 rota and a 'consultant of the week' system to ensure good continuity of care. Macgregor Ward was an 18 bedded in-patient ward with seven cubicles, a mobile high dependency bed and an out-patient area. A well-equipped treatment room was also available. The ward was well supplied with computer terminals so that staff had quick and easy access to protocols, guidelines and other information.

Good Practice

1 Approximately a third of registered nurses on the ward had undertaken high dependency training.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 The environment and layout of Macgregor Ward made visibility on the ward difficult, especially as the nurses station was small and could not be in the centre of the Ward. The environment was also quite cluttered. The Trust was considering developing a Paediatric Assessment Unit and reviewers suggested that, if so, the opportunity could be taken to re-organise the whole ward. Commissioners who met the visiting team had not yet received a business case and therefore were not sure if it would represent value for money in terms of the investment required. Further discussions with commissioners about this proposal may be helpful.

2 After 5pm the paediatric service had one middle grade doctor covering the ward, Special Care Baby Unit, Emergency Department and child protection issues, supported by two juniors. Reviewers were told that GP referrals in the early evening could sometimes result in patients waiting in the Emergency Department until a paediatric doctor was available. Reviewers supported the proposal being considered for extending consultant presence into the evening.

3 An audit of staffing for high dependency patients had not yet been undertaken. The ward tried to achieve four registered nurses on early and late shifts and three at nights, sometimes through the use of bank staff. Sickness levels had been high which had made it more difficult to achieve the expected staffing. Reviewers were unsure whether appropriate nursing levels for high dependency patients could be achieved without compromising staffing for other areas of the ward and suggested that an audit of this be undertaken. Ward nursing staff also cared for ward attenders and patients needing phlebotomy, injections and other interventions.

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PAEDIATRIC ANAESTHESIA AND DAY SURGERY

General Comments and Achievements

Paediatric anaesthesia services were well-organised with 47% of elective paediatric surgery taking place on 'Paediatric Fridays'. All anaesthetists were encouraged to rotate through paediatric lists to ensure they were maintaining competence in the care of children. The Department was clearly committed to providing high quality care for children and to integrated working with Emergency Department and paediatric services.

Good Practice

1 The middle grade anaesthetic tier comprised permanent staff grade doctors, all of whom had advanced paediatric life support training. Middle grade staff had also been offered the opportunity to undertake two week placements at Birmingham Children's Hospital in order to ensure competence in the care of children.

2 All services within the Trust were working together to increase the proportion of elective surgery which took place on 'Paediatric Fridays'. At the time of the visit this had reached 47% and there were plans for increasing this further. Lists were carefully planned so that children had left before adult patients arrived.

Immediate Risks: No immediate risks were identified.

Concerns: No concerns were identified.

Further Consideration

1 The main theatre recovery area was not child-friendly, apart from screens with the jungle theme. Corridors, in particular, were very bare.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Dr Rob Alcock	Consultant Anaesthetist	The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Paula Blurton	Sister	University Hospital of North Staffordshire NHS Trust
Dr Jane Cassidy	PICU Consultant	Birmingham Children's Hospital NHS Foundation Trust
Wendy Godwin	Lead Commissioner Planned Care	NHS Walsall CCG
Susan Lownds	CICU Manager	University Hospital of North Staffordshire NHS Trust
Vandna Najran	Specialised Commissioning, Local Service Specialist	NHS England
Dr Titus Ninan	Consultant Paediatrician	Heart of England NHS Foundation Trust
Shiela Pantrini	Senior Paediatric Advanced Clinical Practitioner/Educator	Heart of England NHS Foundation Trust
Dr Bridget Wilson	Consultant in Paediatric Emergency Medicine	Birmingham Children's Hospital NHS Foundation Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service
Charlotte Henderson	Lead Administrator	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Care of Critically Ill and Critically Injured Children			
Acute Trust-wide	8	8	100
Emergency Department	41	34	83
In-Patient Care	53	47	89
Day Surgery	35	29	83
Paediatric Anaesthesia	16	12	75
Total	**153**	**130**	**85**

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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ACUTE TRUST-WIDE

Ref	Quality Standard	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	Transfer of patients from Stratford Minor Injuries Unit to Warwick was covered in an Appendix of the Transfer document. However this could be clearer, for example, around what to do if there were any safeguarding concerns.
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 UHCW CIC appendix D1 20140211emergency surgery on children (QS PG-503).	Y	

Ref	Quality Standard	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.	N/A	
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)	N/A	
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	Minutes and action plans were available but there were no terms of reference for the group.

Ref	Quality Standard	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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Emergency Department

Ref	Quality Standard	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 f. 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	

Ref	Quality Standard	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	No information was available in other languages but a language line 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.	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	N	The only feedback form available was not child-friendly and there was no way of separately identifying feedback either from children or about children.
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	

Ref	Quality Standard	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.	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	Y	A 2005 escalation policy was in place but it did not directly state how staffing levels would respond to fluctuations in the number and dependency of patients. The policy was to tell the nurse in charge.
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.	N	There were insufficient registered children's nurses for each shift but the Trust was in the process of recruitment (see main report).
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	

Ref	Quality Standard	Met?	Comments
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	The play specialist from the ward covered the Emergency Department.
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.	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	Y	

Ref	Quality Standard	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	N	See 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	The Trust used the 'NightHawk' imaging system for overnight imaging.
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)	N/A	
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.	N	See main report
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 Standard	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	See main report
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	Y	
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 protocol was in place.

Ref	Quality Standard	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	No protocol was in place. Any transfers were led by paediatrics and who was involved would depended on staff available and presenting symptoms. KIDS (Kids Intensive Care and Decision Support) was used if available.
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	Y	
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	A Trust Organ Donation policy was in place but did not cover children. This was, however, covered in the Bereavement Policy.

Ref	Quality Standard	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	The Trust bereavement policy was contained within the in-patient policy. Reviewers suggested that this policy be amended to make explicit that it applied to the Emergency Department.
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	N/A	
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	N/A	

Ref	Quality Standard	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	N/A	
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'.	N	Review and learning arrangements were not clear. There was some discussion at a senior level but it was not clear if this was fed back to junior staff. A three monthly PALS (Patient Advice and Liaison Service) report was produced.
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 CARE

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 f. 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 facilities would benefit from an update and refresh. The ward had received many public donations of equipment and toys, indicating that the service was valued but this had resulted in a cluttered 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	
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	No information was available in other languages but a language line 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.	Y	
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	As PM-105.

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	Parents could use a chair bed in the quiet room.
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	N	Feedback mechanisms were not yet available but the Trust was working on this.
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	

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.	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	Y	The majority of registered staff had either PLS (Paediatric Life Support) or EPLS (European Paediatric Life Support).
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	

Ref	Quality Standards	Met?	Comments
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	Y	
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.	Y	
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.	N	No audit of staffing levels for high dependency care had been undertaken. See also main report.
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.	N/A	
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	

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	Y	
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	All staff had level 2 training and the senior nurses had level 3.
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.	N	See main report
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	

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	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	See main report.
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	

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	Y	
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 protocol was in place.
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	No protocol was in place. Any transfers were led by paediatrics and who was involved would depended on staff available and presenting symptoms. KIDS (Kids Intensive Care and Decision Support) was used if available.

Ref	Quality Standards	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	Y	
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	A Trust Organ Donation policy was in place but did not cover children. This was, however, covered in the Bereavement Policy.
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	

Ref	Quality Standards	Met?	Comments
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	The policy covered diabetic ketoacidosis and acute asthma. Children needing other high dependency care were transferred out.
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	
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'.	N	Review and learning arrangements were not clear. There was some discussion at a senior level but it was not clear if this was fed back to junior staff. A three monthly PALS (Patient Advice and Liaison Service) report was produced. The team did meet with KIDS (Kids Intensive Care and Decision Support) to discuss Paediatric Intensive Care Unit transfers.
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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DAY SURGERY

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.	N	This standard was met on 'paediatric Friday' but children were operated on at other times during the week.
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	
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.	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	N	Smiley face feedback cards were available. Point 'b' was not met.

Ref	Quality Standards	Met?	Comments
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	
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	

Ref	Quality Standards	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.	N	The standard was met on 'paediatric Fridays' by using a nurse from the ward but not when children had their surgery on other days.
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	A dedicated play specialist was available on 'paediatric Fridays'. The play specialist from the ward was available if needed at other times.
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	Y	
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	
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.	N	The same checklist was used as for the theatre trolley but it was not checked weekly.
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/A	
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	See main report.

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	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	Y	
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 protocol was in place.
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	

Ref	Quality Standards	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	Y	
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	A Trust Organ Donation policy was in place but did not cover children. This was, however, covered in the Bereavement Policy.
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	
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.	N/A	

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'.	N	Review and learning arrangements were not clear. There was some discussion at a senior level but it was not clear if this was fed back to junior staff. A three monthly PALS (Patient Advice and Liaison Service) report was produced.
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 Standard	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	Good information was available for both adults and children.
PG-199	**Involving children and families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service	N	The service collected feedback and there was evidence of some liaison with PALS (Patient Advice and Liaison Service) but there were no records of any changes made. The Trust had plans to put feedback on the Datix system in order to look at trends. Any concerns were taken to the monthly patient forum.
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 Standard	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	The majority of anaesthetists attended internal CPD (Continuing Professional Development) through the monthly audit meeting and over 50% were either APLS (Advanced Paediatric Life Support) or EPLS (European Paediatric Life Support) trained. All second tier resident doctors had advanced paediatric life support training.
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	As PG-204. All anaesthetists contributed to elective lists in order to maintain skills.
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	65% of all ODPs (Operating Department Practitioners) had PLS (Paediatric Life Support) or equivalent and plans were in place to ensure that all had PLS by the end of the year to ensure that outside of 'Paediatric Fridays' there would always be someone available with paediatric 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.	Y	80% of the recovery staff had PLS (Paediatric Life Support) and 100% had recovery competences.
PG-401	**Induction and recovery areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	N	The anaesthetics rooms were not child-friendly and the recovery areas were temporarily decorated with jungle-themed screens. The corridors were not child friendly. See main report.

Ref	Quality Standard	Met?	Comments
PG-402	**Day surgery** Children needing elective surgery should be admitted to a day surgery unit or a children's ward area specifically identified for children's day surgery.	Y	
PG-403	**Drugs and equipment** Appropriate drugs and equipment should be available in each area in which paediatric anaesthesia is delivered. Drugs and equipment should be checked in accordance with local policy.	N	The trolleys had been checked weekly (in line with the Trust policy) for the last four weeks but not before then and there was no record for checking the expiry dates of equipment and consumables. There was a good, well equipped and sealed airway stabilisation trolley in theatre and drugs were checked.
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	
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 Standard	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	Criteria were very clear.
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 not available, although the service did not run separate pre-operative assessment. The guidelines for analgesia for children were very good.
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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