WM QRS West Midlands Quality Review Service

NHS

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

The Royal Wolverhampton NHS Trust

Visit Dates: 11th June 2013 and 14th July 2015 Report Date: November 2015

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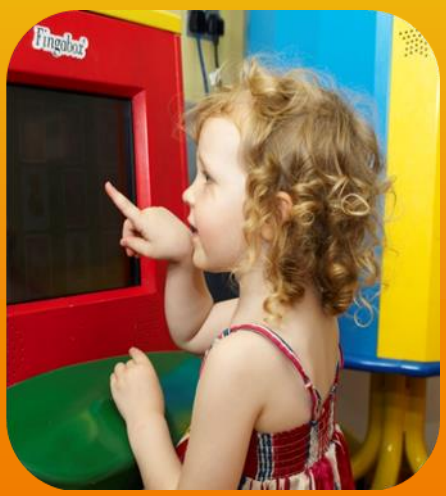

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INTRODUCTION

This report presents the findings of the review of the care of critically ill and critically injured children at The Royal Wolverhampton NHS Trust. A full review of the care of critically ill and critically injured children at the Trust was undertaken on 11th June 2013 as a pilot visit testing the revised Standards for the Care of Critically Ill and Critically Injured Children in the West Midlands. A re-visit to the Emergency Department took place on 14th July 2015.

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. These visits reviewed 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 (2013 pilot visit) and Version 4.2, December 2013 (2015 re-visit to Emergency Department)

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 visits. The text of this report identifies the main issues raised during the course of the visits. Appendix 1 lists the visiting teams which reviewed the services at The Royal Wolverhampton NHS Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

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

- The Royal Wolverhampton NHS Trust
- NHS Wolverhampton 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 Wolverhampton Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is 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 The Royal Wolverhampton NHS Trust for their hard work in preparing for the reviews and for their kindness and helpfulness during the course of the visits. Particular thanks are due because of the Trust's agreement to pilot Version 4 of the Standards with little preparation time. Thanks are also due to the visiting teams and their employing organisations for the time and expertise they contributed to these reviews.

CARE OF CRITICALLY ILL AND CRITICALLY INJURED CHILDREN

The pilot visit on 11th June 2013 reviewed the following services for children at The Royal Wolverhampton NHS Trust: paediatric wards, Emergency Department, Beynon Centre (day surgery) and paediatric anaesthesia services. The Emergency Department was then re-visited on 14th July 2015.

TRUST-WIDE: 2013

Reviewers were impressed with the attitude of and approach of all the staff they met, in particular, their commitment to the care of children and keenness to improve the services offered. This was reflected in the decision of the Trust to volunteer to be one of the early sites in the 2013/14 visiting programme.

Good Trust-wide arrangements governing the care of children were in place, including a Trust-wide Children and Young People's Committee, a 'Deteriorating Patient' Committee, a three monthly Care of Critically Ill and Child Committee, Resuscitation Committee and monthly Acute Paediatric Governance Committee, as well as robust arrangements for reviews of child deaths and of transfers to paediatric intensive care units.

Increasing cooperation between services was also clear throughout the visit, in particular, increased involvement of paediatricians in the management of acutely unwell children in the Emergency Department, appointment of consultants to work across both the Emergency Department (ED) and Paediatric Assessment Unit, shared protocols and joint governance meetings between the ED and paediatric services. Good joint working between paediatric, surgical and anaesthetic services was also evident with shared care of general surgical patients and clear arrangements for paediatric input to the care of all children needing surgery.

A strong commitment to education and training was also evident. Regular 'in service' days were held for paediatric and ED nursing staff. A comprehensive junior doctor training programme in the care of children included weekly case presentations, lunchtime meetings, a journal club, fortnightly advance paediatric life support (APLS) scenarios, grand rounds and audit afternoons also took place and simulation ward training was available and well used.

Concerns

1 Resuscitation trolleys for adults and children were different colours in different areas of the hospital. On the paediatric ward the paediatric trolley was red and the adult trolley blue. In all other areas of the hospital the adult trolley was red and the paediatric trolley blue. This decision had been made because of the larger size of the red trolleys and the need for more equipment on the paediatric ward. Reviewers were concerned about the potential for confusion, especially because of the extent of joint working of medical and nursing staff between the ED and paediatric ward. The associated risk was mitigated, however, because use of the trolley was always under the supervision of the team who knew the area and were acquainted with the trolleys.

2 Some protocols and guidelines were out of date or undated, and some were still available in paper form when more recent versions were available on the intranet. The Trust document approval procedure did not apply to all departmental guidelines and policies and there was no system of flagging documents needing updating. The paediatric department had, however, recently identified an individual to take the lead role on managing guidelines and protocols relating to the care of children.

Further Consideration

1 Each area where children may be seen had resuscitation equipment available. Resuscitation trolleys had been classified as 'low', 'medium' and 'high' specification in order to avoid confusion and reduce wastage. Low and medium specification trolleys were standardised across the Trust. The drugs and equipment on high specification trolleys was different in different departments. It may be helpful to consider standardisation of high specification trolleys. Clear labelling of the different types of trolley, and indicating on low and medium specification trolleys where additional equipment could be obtained may also be

helpful. Responsibility for checking the defibrillator had been omitted from the latest version of the equipment checklist.

2 The Trust was moving towards the use of electronic patient and family information. Ways of making sure that children, young people and families know about information that is available may benefit from further consideration.

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EMERGENCY DEPARTMENT: 2015

General Comments and Achievements

The Emergency Department at New Cross Hospital served a Wolverhampton population of about 250,000 plus surrounding areas. The number of patients attending the paediatric Emergency Department was 19,416 in 2013 and 21,105 in 2014.

Significant progress had been made since the 2013 pilot visit. Two new paediatric consultants had joined the team and had brought enthusiastic leadership for operational service improvement and for policy development. As well as weekends on a rota with adult consultants, the paediatric consultants worked clinical shifts on Monday, Tuesday, Thursday and Friday each week during which time children and young people were seen in a separate paediatric work-stream. A junior doctor was assigned to work in the paediatric area 3pm to 11 pm each weekday.

Since the previous visit nurses had been given the opportunity for secondment to the Paediatric Assessment Unit whilst a nurse from the Paediatric Assessment Unit was seconded to the Emergency Department. This had improved mutual understanding about the services. A nurse with paediatric skills was assigned to the paediatric area from 10 am to 10 pm seven days a week and a lead nurse responsible for the care of children in the Department had been identified.

Many of the clinical processes and guidelines had also been reviewed and improved, including checking of resuscitation trolleys.

The Department was moving to a new facility in November 2015 and preparations for the move were underway.

Good Practice

1 A liaison health visitor reviewed notes of all Emergency Department attendances by children and young people. This was particularly useful for picking up children who may not initially have been referred to the liaison service.

Immediate Risks [1]

1 The children's waiting area was completely visually separate from the adult waiting area but there were no staff in the paediatric waiting or treatment area when reviewers visited and no nurse was allocated to work there. Two children were in cubicles in the paediatric treatment area, including one on a nebuliser. Reviewers were told that families were advised to call if they needed help but there were no formal arrangements, for example, regular checks on the paediatric area and it was not clear how parents should call for help. Reviewers were very concerned that children were being triaged into an unstaffed area with no visual oversight. They were told that staffing levels were particularly low on the day of the visit (three

[1] **Trust Response:** Following the visit the following actions have been taken: Internal investigation which identified a failure to follow agreed escalation processes by certain staff. Escalation process reviewed to ensure it is clear and comprehensive. A nurse is allocated to work in paediatric area between 10..-22.00, this will be monitored by Unit manager daily and compliance reported to Divisional Head of Nursing weekly. A standard operating protocol is in place for the care of paediatric patients within the department which includes how the paediatric area is staffed outside of 10.00-22.00. Recruitment to paediatric nurse vacancies to ensure there is a paediatric trained nurse 24/7. Additional senior nursing support has been provided to review the nursing workforce and rostering of the workforce.
WMQRS Response: The actions as detailed address the immediate risk identified during the visit.

nursing staff less than the expected number) but having no staff in the paediatric area was not an unusual occurrence and priority was given to staffing the busier adult area. When fully staffed the paediatric area was staffed by one nurse working a long day (10am to 10pm). This issue was identified in 2013 and had not been addressed.

Concerns

1 **Children's Nurse Staffing Levels**

The number of children's trained nurses was insufficient to ensure a registered children's nurse was on duty at all times. It was also unclear whether registered children's nurses were actively being recruited. Some children's trained nurses did rotate into the Emergency Department from the Paediatric Assessment Unit.

2 **Checking of Resuscitation Trolleys**

Evidence that resuscitation trolleys were checked on a daily basis, as required by Trust policy, was not available. Checks of the trolley in the resuscitation area were recorded on only 20 of the 30 days in June 2015. **'**Grab bags' containing transfer equipment were not sealed and were checked only monthly. Checking records showed that some items were missing and only the first page of the two page checks was completed. Resuscitation equipment was laid out in different places on the trolleys seen by reviewers, with no standard layout.

3 **Safeguarding Training**

Data available to reviewers showed that staff groups ranged between 22% and 78% completion of appropriate level safeguarding training. Only two of the middle grade medical staff and seven of the nine consultants had up to date safeguarding training.

Further Consideration

1 Staff who met the visiting team were not clear about how appropriate nurse staffing levels for the paediatric area in the new building were going to be achieved. Reviewers suggested that this should be addressed as a matter of urgency as the paediatric area in the new building will be separate from the adult area.

2 Information on paediatric life support training was not easily accessible and it was therefore difficult for service managers to ensure that all staff were up to date. This issue was identified in 2013 and had not yet been addressed.

3 Document control arrangements were not yet robust. Some guidelines appeared to be out of date although this may have been because the new consultants had inherited PDF versions of documents which had been checked and given new footers but which were not yet in the Trust document control format. This issue was identified in 2013 and had not yet been addressed. Some paper copies of out of date resuscitation algorithms and guidelines were also still available in a folder.

4 The Emergency Department cards in use for recording patient contacts in the Department had been developed for adult use and many aspects were not applicable to children and young people. Reviewers suggested that consideration should be given to developing paediatric-specific documentation.

5 Reviewers acknowledged the Trust policy for providing different levels of resuscitation equipment (high, medium and low), but considered that this may be confusing for locum staff. Reviewers also commented that the equipment did not appear to be stored in a logical fashion as the airway equipment was lower than circulatory equipment. Locum or temporary staff not familiar with the order may expect to find airway equipment. Also, in practice staff did not appear to be following the Trust policy on use of the 'grab bags' and were taking the equipment required rather than the whole bag.

6 Reviewers suggested that consideration be given to ongoing support and guidance for the two paediatric Emergency Department consultants to ensure they are able fully to fulfil their obvious leadership potential

and to achieve the improvements in services for children and young people that they would like to implement.

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IN-PATIENT SERVICE: 2013

General Comments and Achievements

Staff of the paediatric service were proactively developing and improving the care that was available, with strong medical and nursing leadership effectively driving regular, ongoing improvements. The paediatric in-patient service had very good facilities for the care of children and young people, including a sensory room, school room, play area, good parent facilities and a new forensic suite. These were all clean and tidy.

A high proportion of nurses had undertaken additional training in high dependency care and, as a result, sufficient nurses with competences in high dependency care were available to meet the fluctuating need for these skills.

The service was effectively linking with Emergency Department (ED), surgical and anaesthetic colleagues, and nurse rotation with the ED had been re-introduced.

Good Practice

1 A good 'Patient Feedback Tree' was being used and there was clear evidence of feedback being used to improve services, for example, arrangements for medication to take home, parent beds, children's food and pictures on the walls.

2 A system had been developed whereby when a patient scored 'red' or 'amber' on the early warning system a sticker was put in their notes to say that the doctor had been called. The doctor initialled this sticker when they arrived to see the child. This system supported good communication between nursing and medical staff and enabled audit and review if delays occurred.

Immediate Risks: No immediate risks were identified.

Concerns: See Trust-wide section of this report.

Further Consideration

1 Audit of staffing of the high dependency unit to confirm that appropriate staffing levels are being met may be helpful.

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OTHER PAEDIATRIC AREAS: DAY SURGERY UNIT – BEYNON CENTRE: 2013

See Paediatric Anaesthesia section of this report.

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PAEDIATRIC ANAESTHESIA: 2013

General Comments and Achievements

The Trust had a clear policy on surgery on children and effective leadership and links between anaesthetic, surgical and paediatric services were evident. Considerable effort had been put into making the surgical experience as child-friendly as possible, including use of the paediatric 'Feedback Tree'.

A good display board highlighted 'never events' and clinical incidents and provided feedback of the action taken. Another board covered staff training and when it was due. The boards helped to ensure good communication and involvement of staff.

Once a month, a 'Paediatric Tuesday' was held when the Beynon Centre Day Theatres One and Two were used only for children and young people. This allowed concentration of paediatric lists and efficient use of paediatric-skilled staff.

Good Practice

1 Paediatric recovery areas were very child-friendly with well equipped paediatric trolleys for dealing with emergencies and dedicated staff to look after the children.

2 Very good pre-operative assessment arrangements were in place. Every child received pre-operative assessment, including those for MRI. Pre-operative assessments were undertaken every Thursday in a specific area in the day surgery unit of the Children's Ward with an anaesthetist available if there was a problem or for advice. Good information for children, young people and parents was available, including a video about anaesthesia and surgery. This was a very efficient way of organising pre-operative assessment and provided good support for children and families.

3 A clear, comprehensive information leaflet was available which could be printed in different languages if necessary.

Immediate Risks: No immediate risks were identified.

Concerns: See Trust-wide section of this report.

Further Consideration

1 Six anaesthetists had a particular interest in the care of children and young people. The full anaesthetic on-call rota involved 29 anaesthetists. The level of experience of anaesthetists who are not regularly involved in the care of children should be kept under review to ensure competence is maintained. As part of its strategic development the Trust may also wish to consider the development of a separate paediatric anaesthesia rota.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

VISITING TEAM: 2013

Dr John Alexander	Clinical Director, PICU	University Hospital of North Staffordshire NHS Trust
Lisa Armour	Acting Manager Children's ED	University Hospitals Coventry & Warwickshire NHS Trust
Dr Suja Chari	Consultant Anaesthetist	University Hospitals Coventry & Warwickshire NHS Trust
Helen Cope	Lead Resuscitation Officer	Sandwell and West Birmingham Hospitals NHS Trust
Dr James Davidson	Clinical Director Emergency Medicine	University Hospitals Coventry & Warwickshire NHS Trust
Sue Ellis	Lead Nurse Paediatrics & Neonatology	University Hospitals Coventry & Warwickshire NHS Trust
Rachael Haskins	SSN Paediatrics	Burton Hospitals NHS Foundation Trust
Dr Titus Ninan	Consultant Paediatrician	Heart of England NHS Foundation Trust
Sue Eardley	Head of Invited Reviews and Child Health	Royal College of Paediatrics
WMQRS Team		
Jane Eminson	Acting Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service

VISITING TEAM: 2015

Helen Cope	Lead Resuscitation Officer	Sandwell & West Birmingham Hospitals NHS Trust
Dr James Davidson	Clinical Director Emergency Medicine	University Hospitals Coventry & Warwickshire NHS Trust
Sue Ellis	Lead Nurse Paediatrics & Neonatology	University Hospitals Coventry & Warwickshire NHS Trust
Nick Flint	User Representative	
Paula Lane	Lead Nurse, Paediatric Emergency Department	Heart of England NHS Foundation Trust
WMQRS Team		
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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 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: 2013	10	8	80
Emergency Department: 2015	44	34	77
In-patient Service: 2013	53	50	94
Other Paediatric Areas: Day Surgery Unit – Beynon Centre: 2013	34	32	94
Paediatric Anaesthesia: 2013	20	20	100
Total	**161**	**144**	**89**

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

TRUST-WIDE: 2013

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	The nominated lead consultant for the Emergency Department was not undertaking regular clinical work in the department.
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	All paediatric referrals to the on-call senior house officer for assessment.
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? Y/N	Reviewer Comment
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	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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.	N	A group existed and met regularly but the Resuscitation Officer with lead responsibility for children was not a member.
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.	N	See main report (Trust-wide) section. Additional detail is also provided in the comments to QSs PM-799.
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: 2015

Ref	Quality Standard	Met? Y/N	Reviewer Comment
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	The quality of some of the information seen by reviewers was variable as it had been photocopied multiple times. There did not seem to be a clear process for managing family support following the sudden death of a child in the department. Information in other languages or information about how to access information in other languages or how to access an interpreter was not seen. The waiting area had been flooded two weeks prior to the review visit and so was not in use. A room adjacent to the viewing room was being used instead. The viewing room did not have any signage to say that it may be in use.
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.	N	Information was written for adults and had not yet been tailored for the needs of children or young people. No information about national help lines or advice was seen by reviewers.
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	Reviewers spoke to parents who felt they had been fully informed of their child's condition and plan of care.

Ref	Quality Standard	Met? Y/N	Reviewer Comment
PM-108	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents.	Y	Financial help for families was included in the transfer policy and staff gave verbal information to parents.
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	Reviewers saw no evidence of the involvement of children or families in decisions about the management of the service. A competition about the environment in the new build had involved children in the design. Some feedback was obtained from parents which was reported to the Trust Board but it was not clear whether any changes had been made as a result of this feedback. Trust 'Friends and Family Test' information did not include detail about individual departments.
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	This Quality Standard was met through the immediate availability of paediatric staff.

Ref	Quality Standard	Met? Y/N	Reviewer Comment
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	N	At the time of the visit, one Consultant was not up to date with Advanced Paediatric Life Support 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	
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	N	An escalation policy was not in place to show how staffing would respond to fluctuations in the number and dependency of patients. Evidence of High Dependency Unit (b) or care and rehabilitation of children with trauma (c) competences was not available. 86% of nurses had up to date paediatric life-support training (71 out of 82 nurses).

Ref	Quality Standard	Met? Y/N	Reviewer Comment
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	On the day of the visit to the department no staff were allocated to the children's emergency department area. Rotas available for review showed the establishment was 5.6 w.t.e children's-trained nurses which meant that a children's nurse was not always available in the Emergency Department. Reviewers considered that the department would require a minimum of 5.9 w.t.e to enable appropriate cover.
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	The data presented to reviewers were not clear about the training dates because the latest training attendance date appeared to override previous training.
PM-211	**Support for play** Appropriately qualified play specialists should be available 7 days a week.	N	Appropriately qualified play specialists were not available in the Emergency Department although the team sought advice from the paediatric play specialist. Support from the wards was not always available to the Emergency Department at weekends.
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	

Ref	Quality Standard	Met? Y/N	Reviewer Comment
PE-214	**ED sub-speciality trained consultant** Emergency departments seeing 16,000 or more child attendances per year should have an emergency department consultant with sub-specialty training in paediatric emergency medicine and a consultant paediatrician with sub-specialty training in paediatric emergency medicine.	Y	
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	Only a broad statement on staff acting outside their area of competence was available which did not cover staff de-briefing and links between the Trust policy and Nursing and Midwifery Council / General Medical Council guidance were not clear.
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	Based on the data provided, none of the staff groups were above the Trust standard of 90% staff trained. Staff groups ranged between 22% and 78% completion of training. Only two of the four middle grade medical staff had up to date training. Seven of the nine consultants had up to date training.
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	

Ref	Quality Standard	Met? Y/N	Reviewer Comment
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.	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	
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	

Ref	Quality Standard	Met? Y/N	Reviewer Comment
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	Out of date paper copies of resuscitation algorithms and guidelines were stored in the resuscitation folder in the department.
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.	Y	The protocol which was due for review may benefit from being more specific about the transfer of seriously ill children within the hospital. The protocol seen focussed on the care of the adult with only a paragraph covering transfers of children.

Ref	Quality Standard	Met? Y/N	Reviewer Comment
PM-508	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU.	N/A	
PM-509	**Transfer contingency protocol** A protocol should be in place for situations where retrieval is clinically inappropriate or time-critical, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies, where retrieval may introduce unsafe delay. The protocol should include: a. Advice from the Retrieval Service or lead PIC centre (QS PM-506) b. Contact details of relevant specialists where additional advice may be required, for example, neurosurgeons c. Escort team of one nurse and one doctor with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the medical escort who would normally be senior clinicians with experience and / or training in a) care of the critically ill child or b) emergency transfer or c) airway management. d. Indemnity for escort team e. Availability of drugs and equipment, checked in accordance with local policy f. Arrangements for emergency transport with a local ambulance service and the air ambulance g. Arrangements for ensuring restraint of children, equipment and staff during transfer	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	The policy covered all patients from 0 to 60 years.

Ref	Quality Standard	Met? Y/N	Reviewer Comment
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 policy was in the process of being updated to include latest guidance on end of life care.
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 Standard	Met? Y/N	Reviewer Comment
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	
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	Many documents did not have Trust headers or review dates. Documents agreed from 2015 were document controlled. The team was aware of this issue and had a plan to address it.

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IN-PATIENT SERVICE: 2013

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Very good facilities were available, including a sensory room, play area and forensic suite and also good parent facilities. The team was proactively considering further improvements.
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	Information was available and printed as needed. Distraction toys were available.
PM-105	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child.	Y	
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	Financial help for families was included in the transfer policy and staff gave verbal information to parents
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	An information pack was given to parents on PAU (paediatric assessment unit) and this included a feedback pack with space for children's comments. Ward information also included feedback arrangements.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	
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	A very good 'feedback tree' was in place which linked with the underwater theme. The team were also planning to develop patient forums.
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	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
PM-204	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site.	Y	
PM-205	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training.	Y	
PM-206	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times.	Y	
PM-207	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas.	Y	
PM-208	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Rotation with the Emergency Department had been reintroduced.
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	
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	A high proportion of nurses had undertaken HDU (high dependency unit) training and so sufficient appropriately qualified staff were 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.	N	A flexible staffing system was in place but staffing levels had not yet been audited.
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	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	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	It may be helpful to consider multi-agency input to this training.
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	PACS to Birmingham Children's Hospital was used if a paediatric radiologist was not available locally.
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	The trolley was appropriately stocked and regularly checked. See main report Trust-wide section) regarding colour of trolley and defibrillator checking.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	
PM-501	**Triage** A triage system should be operating which recognises the needs of children and ensures that all non-ambulant patients are triaged immediately.	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	Guidelines were available but some did not have review dates.
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	Appropriate protocols were available in the paediatric ward emergency room but some were out of date. Reviewers were told that staff accessed protocols via the intranet.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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.	Y	
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? Y/N	Reviewer Comment
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	A 'grab bag' had recently been introduced and the equipment list was being developed at the time of the review. Points 'd' and 'g' could be clearer within the policy.
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	The organ donation policy was not child-specific but staff had adopted the ACT Best Practice for the end of life guidance.
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 bereavement policy was not child specific but the Trust had very good paediatric palliative care guidelines, 'Purple Pages'.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	
PQ-701	**High dependency care: data collection** The paediatric high dependency minimum data set should be collected and submitted to SUS.	N	Minimum data set were not yet being collected and submitted to SUS (secondary uses service).
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	Y	
PM-703	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Document control was inconsistent in the documents seen by reviewers. Some policies were undated and some paper documents were seen where more up to date versions were available on the intranet. Some documents had been developed by individual departments and did not adhere to the Trust policy. There was no electronic reminder system in place for updating documents.

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OTHER PAEDIATRIC AREAS: DAY SURGERY UNIT (BEYNON CENTRE): 2013

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Information was available although some was undergoing ratification.
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	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
PM-104	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care.	Y	Every child underwent a preoperative assessment and received good information.
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	Financial help for families was included in the transfer policy and staff gave verbal information to parents
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	A very good 'feedback tree' was in place. Nurses and play leaders were also involved in feedback and consultation with parents.
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.	N/A	
PM-203	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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 f. 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	Point 'c' was not applicable.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Adult and paediatric nurses were available at all times.
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	
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	It may be helpful to consider multi-agency input to this training.
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	PACS to Birmingham Children's Hospital was used if a paediatric radiologist was not available locally.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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 section) regarding colour of trolley and defibrillator checking.
PM-501	**Triage** A triage system should be operating which recognises the needs of children and ensures that all non-ambulant patients are triaged immediately.	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	
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? Y/N	Reviewer Comment
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.	Y	
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? Y/N	Reviewer Comment
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	Points 'd' and 'g' could be clearer within the policy.
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	The organ donation policy was not child-specific but staff had adopted the ACT Best Practice for the end of life guidance.
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 bereavement policy was not child specific but the Trust had very good paediatric palliative care guidelines, 'Purple Pages'.
PM-702	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509).	N	Reviewers did not see evidence of a rolling programme of audit.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	
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	Document control was inconsistent in the documents seen by reviewers. Some policies were undated and some paper documents were seen where more up to date versions were available on the intranet. Some documents had been developed by individual departments and did not adhere to the Trust policy. There was no electronic reminder system in place for updating documents.

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PAEDIATRIC ANAESTHESIA: 2013

Ref	Quality Standards	Met? Y/N	Reviewer Comment
[PC-601]	**Surgery and anaesthetic services** The Trust should be clear whether it provides the following services for children and the hospital site or sites on which each service is available: a. Elective in-patient surgery for children b. Day case surgery for children c. Emergency surgery for children d. Acute pain service for children	Y	Hyper-links between policies worked well.
PG-102	**Information on anaesthesia** Age-appropriate information about anaesthesia should be available for children and families.	Y	Anaesthesia information was available in different languages. Paper information was also good.
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	A very good feedback tree was in place and further work on patient involvement was planned.
PG-201	**Lead anaesthetist** A nominated consultant anaesthetist should be responsible for policies and procedures relating to emergency and elective anaesthesia of children. This consultant should be involved in the delivery of anaesthetic services to children.	Y	
PG-202	**GICU lead consultant** A nominated lead intensive care consultant should be responsible for Intensive Care Unit policies and procedures relating to children.	Y	
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.	Y	
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	Training was linked with the mandatory training system.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	A good board showed training requirements and dates for all staff.
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	Recovery areas were very child-friendly.
PG-401	**Induction and recovery areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	Y	One or two paediatric lists were held in main theatres each day. The Beynon Centre had some paediatric lists during the week. Once a month 'paediatric Tuesdays' were held in the Beynon Centre where only children had surgery
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	Trolleys for adults and children were different colours.
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.	Y	Compliance based on self-assessment.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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	Y	
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	Good guidelines were in place.
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	Informal arrangements were in place and appeared to be working effectively.

Ref	Quality Standards	Met? Y/N	Reviewer Comment
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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