

Care of Critically Ill & Critically Injured Children Quality Review Visit

University Hospitals of North Midlands NHS Trust

Visit Date: 12th September 2018

Report Date: November 2018

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INTRODUCTION

This short report presents the findings of the review of Critically Ill and Critically Injured Children that took place on 12th September 2018. The review visit was commissioned by the West Midlands Paediatric Critical Care Network (WMPCCN), on behalf of commissioners and NHS England who have responsibility for making recommendations on future provision for the delivery of paediatric critical care. This review programme links to both a National Paediatric Critical Care Review; and a West Midlands Paediatric Critical Care CQUIN. The CQUIN outlined a requirement for all West Midlands children's services to be assessed against the WMQRS /Paediatric Intensive Care Society (2016) Standards for the Care of Critically Ill Children (v.5) by July 2017.

The purpose of the visit was to validate the self-assessments made by the acute Trust, and to review the pathway for critically ill children attending the Emergency Department and Children's assessment unit through to inpatient and high dependency inpatient areas where applicable. As part of the WMPCCN programme, information was also gathered about existing capacity to provide paediatric high dependency care at a local level, and the plans that may be required to deliver a higher level of paediatric critical care nearer to the patient's home in the future. Only a select number of Quality Standards were reviewed during this visit. The Quality Standards identified were agreed by the WMPCCN as being important to provide the information required to inform commissioners as part of the National CQUIN for 2017/18. The review visit consisted of a half-day visit, during which reviewers looked at evidence against the self-assessment submitted, met with the lead team for children's services and viewed facilities. This review programme was therefore not as in-depth as the Critically Ill and Critically Injured Children peer review programmes undertaken across the West Midlands in previous years, but was designed to provide specific assurances..

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. Any immediate risks identified include the Trust's response and WMQRS's response to any actions taken to mitigate the risk. Appendix 1 lists the visiting team that reviewed the services at University Hospitals of North Midlands 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:

- University Hospitals of North Midlands NHS Trust
- NHS North Staffordshire 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 North Staffordshire Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive

quality reviews (often through peer review visits), producing comparative information on the quality of services and providing development and learning for all involved.

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

ACKNOWLEDGMENTS

West Midlands Quality Review Service and the West Midlands Paediatric Critical Care Network would like to thank the staff and service users and carers of University Hospitals of North Midlands NHS 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 AND CRITICALLY INJURED CHILDREN

TRUST-WIDE

Immediate Risk: None

Concerns: None

Further Consideration

1. Reviewers considered that the arrangements for calling the resuscitation team would benefit from further discussion and documentation, as the arrangements were not clear in the policy. Staff said that the procedure for calling the paediatric resuscitation team would result in the attendance of a paediatric middle grade clinician, a junior doctor and a paediatric nurse bleep holder. If an anaesthetist with competences in paediatric airway management was required, they would then be bleeped separately. This was not clear in the Trust resuscitation policy. Reviewers felt that there may be a benefit to including the anaesthetist in the first call.

CHILDREN'S EMERGENCY DEPARTMENT (CED) AND CHILDREN'S ASSESSMENT UNIT (CAU)

General Comments

The Emergency Department was a regional centre for adults and children, with trauma patients undergoing stabilisation prior to transfer to Birmingham Children's Hospital. The CAU was situated alongside the Emergency Department and provided 24/7 assessments, including a consultant's opinion if required. The CAU provided eight bed spaces and one resuscitation cubicle.

Good Practice

1. Children attending the CAU were seen very promptly. Data showed that 100% of attendees were assessed within five minutes of arrival.

Concerns:

1. Initial Clinical Assessment

At the time of the visit, data showed that only 80% of children attending the Emergency Department had a brief clinical assessment within 15 minutes of arrival. Reviewers were concerned that children could deteriorate whilst waiting to be seen.

Further Consideration

1. At the time of the visit, only 75% of all staff in the CED had up to date basic paediatric life support and basic adult life support. Reviewers were told that since the child health directorate had become responsible for the children's emergency department nurses, plans had been put in place to ensure that all staff would have appropriate training by mid-October 2018.

INPATIENT WARDS AND PAEDIATRIC HIGH DEPENDENCY UNIT

General Comments and Achievements

Both the wards and the paediatric intensive care unit (PICU) were well run, with good leadership and a proactive approach to service improvement. Staff were enthusiastic and worked well together. Support from the paediatric intensive care unit was very good.

Inpatient paediatric care was provided on two wards, wards 216 and 217. Each ward had 25 beds. Day case surgery (seven beds), elective inpatient surgery and oncology care was provided on ward 217. Ward 216 was a

general paediatric ward that included six high dependency beds, two of which were cubicles, and an additional two cubicles that were used for sleep studies.

Good Practice

1. The environment on the paediatric wards was excellent, spacious, well planned, and well equipped with facilities specifically designed for teenagers and for parents.
2. A mental health liaison worker had been employed by the women's and children's directorate, and reviewers were impressed with the level of mental health training now provided for nursing staff. A study day for paediatric medical staff was also planned.
3. Band 3 & 4 staff were providing some care for children and young people on long-term ventilation who were stable and waiting for care packages to be arranged. A specific training and competence package had been developed covering the skills needed.

Immediate Risks: None

Concerns

1. Ward staffing

Reviewers were concerned at the level of HDU care provided on the wards outside the six designated HDU beds. From the evidence seen, nurse staffing appeared low for the dependency of the patients on the ward, and it was not clear that staff had the appropriate competences, especially when caring for patients with high dependency needs in the specialist areas and at times of peak demand. Staff from the HDU and PICU were flexed to provide cover, but reviewers considered that there was a heavy reliance on staff from PICU to provide support. Reviewers felt that reliance on the high quality of care from PICU and its support for the other services may risk de-skilling staff on ward areas. Some training or sharing of knowledge would improve this.

Further Consideration

1. A number of policies and processes were not yet formalised. In practice, senior staff who met with the reviewers were very clear about arrangements across the departments. Reviewers considered that formalising processes would increase the resilience of the team and provide information for new and temporary staff.
2. Access to Child and Adolescent Mental Health Services (CAMHS) for those residing in north Staffordshire was only available five days a week. Children and young people admitted out of hours on a Friday would therefore not be seen by a member of the CAMHS team until the following Monday. For children and young people residing in south Staffordshire, a seven-day CAMHS service was in place.
3. Data submitted against the Paediatric Critical Care Minimum data set were linked to the patient management system, but data were not captured for the activity taking place in the beds outside the HDU. Reviewers considered that collection of data on HDU activity in all areas would provide more accurate information around the capacity of and demand for the children's services at the Trust.

EXISTING HDU CARE AND PLANS FOR THE FUTURE

As part of the visit, the WMPCCN was keen to hear from staff about their views on the future delivery of critical care for children across the region. The Trust team and reviewers identified several areas for consideration by both the Trust and WMPCCN in the designation and provision of level 2 HDU care across the West Midlands.

1. The management of PICU capacity, with the numbers of children with long-term ventilation needs and requiring sleep studies, is of concern, with children being cared for outside HDU facilities at times of peak demand. The services at UHNM cannot expand exponentially to provide long-term care for children whose care could be delivered closer to home.

2. Identification of 'step down' care closer to home would depend on providers being commissioned appropriately. This would enable appropriate staffing, facilities and equipment to be funded.
3. There needs to be consideration of what level of support might be required from paediatric intensive care units to providers of high dependency care.
4. Support for any work with the wider WMPCCN to develop medical and nursing competences for caring for patients on acute Bilevel Positive Airway Pressure (BiPAP) should be considered.
5. There should be region-wide discussion about the number of different models of ventilator that are in use. Ensuring that sufficient staff have the confidence and competence to care for children requiring ventilation closer to home is problematic for local HDUs if too many different models of ventilator are in use across the region.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Lynne Bowyer	General Manager for Children's Services	University Hospitals Birmingham NHS Foundation Trust
Ally Davies	Network Lead/BWC Transformation Manager	Birmingham Women's and Children's NHS Foundation Trust
Dr Sarah Griffiths	Consultant Paediatrician	University Hospitals Coventry & Warwickshire NHS Trust
Amrat Mahal	Head of Children and Young Peoples Nursing, Women's and Children's Division	Worcestershire Acute Hospitals NHS Trust
Caroline Whyte	Divisional Director of Nursing Children, Young People and Neonates (Acute and Community) WCCSS	Walsall Healthcare NHS Trust

WMQRS Team		
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

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

Table 1 - Percentage of Quality Standards met

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of applicable QS	Number of QS met	% met
Trust Wide	10	9	90
Children's Emergency Department	21	19	90
Children's Assessment Unit	23	23	100
Inpatient Wards & Level 1	30	28	93
Level 2	27	24	89
Health Economy	111	103	93

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HOSPITAL-WIDE

Ref	Standard	Met?	Reviewer's comments
HW-201	<p>Board-Level Lead for Children</p> <p>A Board-level lead for children's services should be identified.</p>	Y	
HW-202	<p>Clinical Leads</p> <p>The Board-level lead for children's services should ensure that the following leads for the care of children have been identified:</p> <ol style="list-style-type: none"> Lead consultants and nurses for each of the areas where children may be critically ill (QS **-201) Lead consultant for paediatric critical care Lead consultant for surgery in children (if applicable) Lead consultant for trauma in children (if applicable) Lead anaesthetist for children (QS A-201) Lead anaesthetist for paediatric critical care (QS A-202) Lead GICU consultant for children (QS A-203) (if applicable) Lead consultant/s and lead nurse/s for the Specialist Paediatric Transport Service (QS T-201) (if applicable) Lead consultant and lead nurse and for safeguarding children Lead allied health professional for the care of critically ill children 	Y	
HW-203	<p>Hospital Wide Group</p> <p>Hospitals 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 HW-202) and the Resuscitation Officer with lead responsibility for children.</p> <p>The accountability of the group should include the Hospital Lead for children's services (QS HW-201). The relationship of the group to the Trust's mechanisms for safeguarding children and clinical governance issues relating to children should be clear.</p>	Y	Children's Hospital Board.

Ref	Standard	Met?	Reviewer's comments
HW-204	<p>Paediatric Resuscitation Team</p> <p>A paediatric resuscitation team should be immediately available at all times, comprising at least three people:</p> <ol style="list-style-type: none"> A Team Leader with up to date advanced paediatric resuscitation and life support knowledge and competences and at least Level 1 RCPCH (or equivalent) competences (QS PM-203) A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences <p>An anaesthetist, or other practitioner, with up to date competences in advanced paediatric resuscitation and life support and advanced airway management</p>	Y	
HW-205	<p>Consultant Anaesthetist 24 Hour Cover</p> <p>A consultant anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management who is able to attend the hospital within 30 minutes and does not have responsibilities to other hospital sites should be available 24/7.</p>	Y	
HW-206	<p>Other Clinical Areas</p> <p>Staff in other clinical areas where children may be critically ill, such as imaging and paediatric out-patient departments, should have basic paediatric resuscitation and life support training.</p>	Y	
HW-401	<p>Paediatric Resuscitation Team – Equipment</p> <p>The paediatric resuscitation team should have immediate access to appropriate drugs and equipment which are checked in accordance with local policy.</p>	Y	
HW-501	<p>Resuscitation and Stabilisation</p> <p>Protocols should be in use covering resuscitation and stabilisation, including:</p> <ol style="list-style-type: none"> Alerting the paediatric resuscitation team Arrangements for accessing support for difficult airway management Stabilisation and ongoing care Care of parents during the resuscitation of a child 	Y	However, see further consideration of the report on clarity in documented policy

Ref	Standard	Met?	Reviewer's comments
HW-598	<p>Trust-Wide Guidelines</p> <p>The following Trust-Wide guidelines should be in use:</p> <ul style="list-style-type: none"> a. Consent b. Organ and tissue donation c. Palliative care d. Bereavement e. Staff acting outside their area of competence covering: f. Exceptional circumstances when this may occur g. Staff responsibilities h. Reporting of event as an untoward clinical incident i. Support for staff 	N	The QS was met apart from 'e'.
HW-602	<p>Paediatric Critical Care Operational Delivery Network Involvement</p> <p>At least one representative from the Trust should attend each meeting of the Paediatric Critical Care Operational Delivery Network. Information about the work of the network should be disseminated to all staff involved in the provision of critical care for children</p>	Y	

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EMERGENCY DEPT

Ref	Standard	Met?	Reviewer's comments
ED-201	<p>Lead Consultant and Lead Nurse</p> <p>A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.</p>	Y	
ED-202	<p>Consultant Staffing</p> <p>a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7</p> <p>b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children</p>	Y	
ED-203	<p>'Middle Grade' Clinician</p> <p>A 'middle grade' clinician with the following competences should be immediately available at all times:</p> <p>a. Advanced paediatric resuscitation and life support</p> <p>b. Assessment of the ill child and recognition of serious illness and injury</p> <p>c. Initiation of appropriate immediate treatment</p> <p>d. Prescribing and administering resuscitation and other appropriate drugs</p> <p>e. Provision of appropriate pain management</p> <p>f. Effective communication with children and their families</p> <p>g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant</p> <p>A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be Specialist Trainee 4 (ST4) or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
ED-206	<p>Competence Framework and Training Plan – Staff Providing Bedside Care</p> <p>A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including:</p> <ul style="list-style-type: none"> a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS ED-208) and expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems 	N	<p>At the time of the visit, only 75% of staff had up to date paediatric basic life support training. Some staff were also not up to date with adult basic life support training. Of the band 6 and 7 nurses, 50% had advanced paediatric resuscitation and life support competences. Of the band 5 nurses, 87.5% had paediatric immediate life support competences.</p>
ED-207	<p>Staffing Levels: Bedside Care</p> <p>Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation C12policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved:</p> <ul style="list-style-type: none"> a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least one registered children's nurses on duty at all times in each area 	Y	

Ref	Standard	Met?	Reviewer's comments
ED-209	<p>Other Staffing</p> <p>The following staff should be available:</p> <ul style="list-style-type: none"> a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) c. Access to dietetic service (at least 5/7) d. Access to a liaison health worker for children with mental health needs (7/7) e. Access to staff with competences in psychological support (at least 5/7) 	Y	
ED-211	<p>ED Liaison Paediatrician</p> <p>A nominated paediatric consultant should be responsible for liaison with the nominated Emergency Department consultant (QS ED-201).</p>	Y	
ED-212	<p>ED Sub-speciality Trained Consultant</p> <p>Emergency Departments seeing 16,000 or more child attendances per year should have a consultant with sub-specialty training in paediatric emergency medicine.</p>	Y	
ED-301	<p>Imaging Services</p> <p>24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Hospital should have arrangements for review of imaging by a paediatric radiologist.</p>	Y	
ED-401	<p>Resuscitation Equipment</p> <p>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.</p>	Y	
ED-402	<p>Grab Bag'</p> <p>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
ED-501	<p>Initial Assessment</p> <p>A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.</p>	N	Only 80% of children had a brief clinical assessment within 15 minutes of arrival.
ED-502	<p>Paediatric Early Warning System</p> <p>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.</p>	Y	
ED-503	<p>Resuscitation and Stabilisation</p> <p>Hospital-Wide protocols for resuscitation and stabilisation should be in use, including:</p> <ol style="list-style-type: none"> Alerting the paediatric resuscitation team Arrangements for accessing support for difficult airway management Stabilisation and ongoing care Care of parents during the resuscitation of a child 	Y	
ED-504	<p>Paediatric Advice</p> <p>Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.</p>	Y	
ED-505	<p>Clinical Guidelines</p> <p>The following clinical guidelines should be in use:</p> <ol style="list-style-type: none"> Treatment of all major conditions, including: <ol style="list-style-type: none"> acute respiratory failure (including bronchiolitis and asthma) sepsis (including septic shock and meningococcal infection) management of diabetic ketoacidosis seizures and status epilepticus trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) burns and scalds cardiac arrhythmia upper airway obstruction Management of acutely distressed children, including use of restraint Drug administration and medicines management Pain management Procedural sedation and analgesia Infection control and antibiotic prescribing Tissue viability, including extravasation 	Y	

Ref	Standard	Met?	Reviewer's comments
ED-506	<p>PCC Transfer Guidelines</p> <p>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:</p> <ul style="list-style-type: none"> a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained 	Y	
ED-507	<p>In-hospital Transfer Guidelines</p> <p>Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.</p>	Y	
ED-508	<p>Inter-hospital Transfer Guidelines</p> <p>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:</p> <ul style="list-style-type: none"> a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer 	Y	

Ref	Standard	Met?	Reviewer's comments
ED-509	<p>Time-Critical Transfer Guidelines</p> <p>Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include:</p> <ul style="list-style-type: none"> a. Securing advice from the Specialist Paediatric Transport Service (QS ED-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS ED-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer 	Y	
ED-798	<p>Review and Learning</p> <p>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'.</p>	Y	

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CHILDREN'S ASSESSMENT SERVICE

Ref	Standard	Met?	Reviewer's comments
CA-201	<p>Lead Consultant and Lead Nurse</p> <p>A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.</p>	Y	
CA-202	<p>Consultant Staffing</p> <p>a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7</p> <p>b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children</p>	Y	
CA-203	<p>'Middle Grade' Clinician</p> <p>A 'middle grade' clinician with the following competences should be immediately available at all times:</p> <p>a. Advanced paediatric resuscitation and life support</p> <p>b. Assessment of the ill child and recognition of serious illness and injury</p> <p>c. Initiation of appropriate immediate treatment</p> <p>d. Prescribing and administering resuscitation and other appropriate drugs</p> <p>e. Provision of appropriate pain management</p> <p>f. Effective communication with children and their families</p> <p>g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant</p> <p>A clinician with at least Level 1 RCPC (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-206	<p>Competence Framework and Training Plan – Staff Providing Bedside Care</p> <p>A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including:</p> <ul style="list-style-type: none"> a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS CA-208) and expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems 	Y	<p>92% of staff had basic paediatric and adult life support training (2 staff on long term leave). 100% of band 6 and 7 staff had advanced paediatric resuscitation and life support competences and 90 % of band 5 staff had paediatric immediate life support competences.</p>
CA-207	<p>Staffing Levels: Bedside Care</p> <p>Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff.</p> <p>The following minimum nurse staffing levels should be achieved:</p> <ul style="list-style-type: none"> a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area 	Y	

Ref	Standard	Met?	Reviewer's comments
CA-209	<p>Other Staffing</p> <p>The following staff should be available:</p> <ul style="list-style-type: none"> a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) c. Access to dietetic service (at least 5/7) d. Access to a liaison health worker for children with mental health needs (7/7) e. Access to staff with competences in psychological support (at least 5/7) 	Y	
CA-301	<p>Imaging Services</p> <p>24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Hospital should have arrangements for review of imaging by a paediatric radiologist.</p>	Y	
CA-401	<p>Resuscitation Equipment</p> <p>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.</p>	Y	
CA-402	<p>'Grab Bag'</p> <p>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.</p>	Y	
CA-406	<p>'Point of Care' Testing</p> <p>'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.</p>	Y	
CA-501	<p>Initial Assessment</p> <p>A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.</p>	Y	100% of children had a brief clinical assessment within 5 minutes of arrival.
CA-502	<p>Paediatric Early Warning System</p> <p>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-503	<p>Resuscitation and Stabilisation</p> <p>Hospital-Wide protocols for resuscitation and stabilisation should be in use, including:</p> <ul style="list-style-type: none"> a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child 	Y	
CA-504	<p>Paediatric Advice</p> <p>Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.</p>	Y	
CA-505	<p>Clinical Guidelines</p> <p>The following clinical guidelines should be in use:</p> <p>All:</p> <ul style="list-style-type: none"> a. Treatment of all major conditions, including: <ul style="list-style-type: none"> i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) 	Y	

Ref	Standard	Met?	Reviewer's comments
CA-506	<p>PCC Transfer Guidelines</p> <p>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:</p> <ul style="list-style-type: none"> a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained 	Y	
CA-507	<p>In-hospital Transfer Guidelines</p> <p>Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.</p>	Y	
CA-508	<p>Inter-hospital Transfer Guidelines</p> <p>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:</p> <ul style="list-style-type: none"> a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer 	Y	

Ref	Standard	Met?	Reviewer's comments
CA-509	<p>Time-Critical Transfer Guidelines</p> <p>Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include:</p> <ol style="list-style-type: none"> a. Securing advice from the Specialist Paediatric Transport Service (QS CA-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS CA-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer 	Y	

Ref	Standard	Met?	Reviewer's comments
CA-601	<p>Operational Policy</p> <p>The service should have an operational policy covering at least:</p> <ul style="list-style-type: none"> a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for a consultant-led rapid access service which can see children within 24 hours of referral g. Arrangements for admission within four hours of the decision to admit h. Types of patient admitted i. Review by a senior clinician within four hours of admission j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff l. Discussion with a senior clinician prior to discharge 	Y	
CA-703	<p>Audit and Quality Improvement</p> <p>The service should have a rolling programme of audit, including at least:</p> <ul style="list-style-type: none"> a. Audit of implementation of evidence based guidelines (QS CA-500s) b. Participation in agreed national and network-wide audits c. Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations 	Y	
CA-704	<p>Key Performance Indicators</p> <p>Key performance indicators should be reviewed regularly with Hospital (or equivalent) management and with commissioners.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-798	<p>Review and Learning</p> <p>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'.</p>	Y	

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INPATIENT WARDS & LEVEL 1 PAEDIATRIC CRITICAL CARE

Ref	Standard	Met?	Reviewer's comments
L1-101	<p>Child-friendly Environment</p> <p>Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities.</p>	Y	
L1-102	<p>Parental Access and Involvement</p> <p>Parents should:</p> <ol style="list-style-type: none"> Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child 	Y	
L1-201	<p>Lead Consultant and Lead Nurse</p> <p>A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.</p>	Y	
L1-202	<p>Consultant Staffing</p> <ol style="list-style-type: none"> A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children 	Y	

Ref	Standard	Met?	Reviewer's comments
L1-203	<p>'Middle Grade' Clinician</p> <p>A 'middle grade' clinician with the following competences should be immediately available at all times:</p> <ul style="list-style-type: none"> a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant <p>A clinician with at least Level 1 RCPC (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.</p>	Y	
L1-205	<p>Medical Staff: Continuity of Care</p> <p>Consultant rotas should be organised to give reasonable continuity of care.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-206	<p>Competence Framework and Training Plan – Staff Providing Bedside Care</p> <p>A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including:</p> <ol style="list-style-type: none"> Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS L1-208) and expected input to the paediatric resuscitation team (QS HW-204) Care and rehabilitation of children with trauma (if applicable) Care of children needing surgery (if applicable) Use of equipment as expected for their role Care of children with acute mental health problems Appropriate level paediatric critical care competences: 70% of nursing staff working on the PCC Units should have appropriate level competences in paediatric critical care. 	N	<p>Ward 216: Of the band 6 and 7 nurses, 23% had advanced paediatric resuscitation and life support competences, of the band 5 nurses, 29% paediatric and adult basic life support competences. 90% of staff had paediatric and adult basic life support competences.</p> <p>Ward 217: 43% of band 7 and 6 nurses have had advanced paediatric resuscitation and life support competences and 47% of band 5 nurses had paediatric and adult basic life support competences. 94.5% of staff had basic paediatric and adult life support training.</p>
L1-207	<p>Staffing Levels: Bedside Care</p> <p>Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited.</p> <p>Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff.</p> <p>The following minimum nurse staffing levels should be achieved:</p> <ol style="list-style-type: none"> At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift At least two registered children's nurses on duty at all times in each area At least one nurse per shift with appropriate level competences in paediatric critical care One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 critical care 	Y	

Ref	Standard	Met?	Reviewer's comments
L1-208	<p>New Starters</p> <p>Nurses and non-registered health care staff without previous paediatric critical care experience should undertake:</p> <ol style="list-style-type: none"> A structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the PCC Unit (or in a higher level unit) A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months <p>Nurses and non-registered health care staff with previous paediatric critical care experience should complete local induction and a review of competence for their expected role.</p>	Y	
L1-209	<p>Other Staffing</p> <p>The following staff should be available:</p> <ol style="list-style-type: none"> Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) Access to a liaison health worker for children with mental health needs (7/7) Access to staff with competences in psychological support (at least 5/7) Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit) Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit) On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) Access to dietetic service (at least 5/7) Access to an educator for the training, education and continuing professional development of staff 	Y	
L1-301	<p>Imaging Services</p> <p>24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Hospital should have arrangements for review of imaging by a paediatric radiologist.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-401	<p>Resuscitation Equipment</p> <p>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.</p>	Y	
L1-402	<p>'Grab Bag'</p> <p>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.</p>	Y	
L1-404	<p>Facilities</p> <p>Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care.</p>	Y	
L1-405	<p>Equipment</p> <p>Equipment, including disposables, should be appropriate for the usual number and age of children and the critical care interventions provided. Equipment should be checked in accordance with local policy.</p>	Y	
L1-406	<p>'Point of Care' Testing</p> <p>'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.</p>	Y	
IP-501	<p>Initial Assessment</p> <p>A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.</p>	Y	
L1-502	<p>Paediatric Early Warning System</p> <p>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.</p>	Y	
L1-503	<p>Resuscitation and Stabilisation</p> <p>Hospital-wide protocols for resuscitation and stabilisation should be in use, including:</p> <ol style="list-style-type: none"> Alerting the paediatric resuscitation team Arrangements for accessing support for difficult airway management Stabilisation and ongoing care Care of parents during the resuscitation of a child 	Y	

Ref	Standard	Met?	Reviewer's comments
L1-504	<p>Paediatric Advice</p> <p>Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.</p>	Y	
L1-505	<p>Clinical Guidelines</p> <p>The following clinical guidelines should be in use:</p> <p>All:</p> <ol style="list-style-type: none"> a. Treatment of all major conditions, including: <ol style="list-style-type: none"> i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) j. Rehabilitation after critical illness (if applicable) 	N	<p>Paediatrics in Partnership guidelines were in place (PIP) but had not been complimented with information for use locally. Guidance covering care for children undergoing surgery, rehabilitation after critical illness was not available to reviewers at the time of the visit.</p>
L1-506	<p>PCC Transfer Guidelines</p> <p>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:</p> <ol style="list-style-type: none"> a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained 	Y	

Ref	Standard	Met?	Reviewer's comments
L1-507	<p>In-hospital Transfer Guidelines</p> <p>Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.</p>	Y	
L1-508	<p>Inter-hospital Transfer Guidelines</p> <p>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:</p> <ol style="list-style-type: none"> Types of patients transferred Composition and expected competences of the escort team Drugs and equipment required Restraint of children, equipment and staff during transfer Monitoring during transfer 	Y	
L1-509	<p>Time-Critical Transfer Guidelines</p> <p>Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include:</p> <ol style="list-style-type: none"> Securing advice from the Specialist Paediatric Transport Service (QS L1-506) Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management Indemnity for escort team Availability of drugs and equipment, checked in accordance with local policy (QS L1-402) Arrangements for emergency transport with a local ambulance service and the air ambulance Arrangements for ensuring restraint of children, equipment and staff during transfer 	Y	

Ref	Standard	Met?	Reviewer's comments
L1-601	<p>Operational Policy</p> <p>All: The service should have an operational policy covering at least:</p> <ol style="list-style-type: none"> Individualised management plans are accessible for children who have priority access to the service (where applicable) Informing the child's GP of their attendance / admission Level of staff authorised to discharge children Arrangements for consultant presence during 'times of peak activity' (7/7) Servicing and maintaining equipment, including 24 hour call out where appropriate Arrangements for admission within four hours of the decision to admit Types of patient admitted Review by a senior clinician within four hours of admission Discussion with a consultant within four hours of admission Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff Discussion with a senior clinician prior to discharge 	Y	
L1-702	<p>Data Collection</p> <p>The service should collect:</p> <ol style="list-style-type: none"> Paediatric Intensive Care Audit Network (PICANet) data Paediatric Critical Care Minimum Data Set for submission to Secondary Uses Service (SUS) 'Quality Dashboard' data as recommended by the PCC Clinical Reference Group (CRG) 	Y	
L1-703	<p>Audit and Quality Improvement</p> <p>The service should have a rolling programme of audit, including at least:</p> <ol style="list-style-type: none"> Audit of implementation of evidence based guidelines (QS L1-500s) Participation in agreed national and network-wide audits Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations 	Y	c was not applicable

Ref	Standard	Met?	Reviewer's comments
L1-704	<p>Key Performance Indicators</p> <p>Key performance indicators should be reviewed regularly with Hospital (or equivalent) management and with commissioners.</p>	Y	
L1-798	<p>Review and Learning</p> <p>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'.</p>	Y	

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LEVEL 2 PAEDIATRIC CRITICAL CARE UNIT

Ref	Standard	Met?	Reviewer's comments
L2-201	<p>Lead Consultant and Lead Nurse</p> <p>A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.</p>	Y	
L2-202	<p>Consultant Staffing</p> <p>a. A consultant who has undertaken relevant training in paediatric critical care, who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7. If the consultant providing cover for the L2 PCC Unit is not a paediatrician, 24 hour cover by a consultant paediatrician who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites is also required</p> <p>b. New appointments to consultant posts in L2 PCCUs should have completed the RCPCH 'Framework of Competences for a Special Study Model in Paediatric Critical Care' (or equivalent) and should have worked for at least six months in a Level 2 and for at least six months in a Level 3 PCCU (or equivalent)</p> <p>c. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children</p>	Y	All consultants had either paediatric critical care experience in caring for children requiring non-invasive ventilation or equivalent experience.

Ref	Standard	Met?	Reviewer's comments
L2-203	<p>'Middle Grade' Clinician</p> <p>A 'middle grade' clinician with the following competences should be immediately available at all times:</p> <ol style="list-style-type: none"> Advanced paediatric resuscitation and life support Assessment of the ill child and recognition of serious illness and injury Initiation of appropriate immediate treatment Prescribing and administering resuscitation and other appropriate drugs Provision of appropriate pain management Effective communication with children and their families Effective communication with other members of the multi-disciplinary team, including the on-duty consultant <p>At least one clinician should be immediately available who is either:</p> <ol style="list-style-type: none"> A paediatric trainee with at least Level 2 RCPCH (or equivalent) competences. Doctors in training should normally be ST6 or above, OR A paediatric trainee (at any RCPCH level) who has completed at least 6 months working in a Level 3 Unit, OR An anaesthetic specialty trainee, OR An advanced nurse practitioner or Hospital / Specialty Doctor with equivalent competences, OR A consultant (QS L2-202) <p>Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.</p>	Y	Middle grade clinicians may not all be ST6 level, but cover was provided by the PICU.
L2-205	<p>Medical Staff: Continuity of Care</p> <p>Consultant rotas should be organised to give reasonable continuity of care.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
L2-206	<p>Competence Framework and Training Plan – Staff Providing Bedside Care</p> <p>A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including:</p> <ul style="list-style-type: none"> a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS L2-208) and expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Appropriate level paediatric critical care competences: 70% of nursing staff working on the PCC Units should have appropriate level competences in paediatric critical care f. Care of children with tracheostomies g. Care of children needing acute and chronic non-invasive ventilation, and tracheostomy ventilation 	N	Ward 216: only 43% of staff had up to date competences in advanced paediatric resuscitation and life support.

Ref	Standard	Met?	Reviewer's comments
L2-207	<p>Staffing Levels: Bedside Care</p> <p>Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff.</p> <p>The following minimum nurse staffing levels should be achieved:</p> <ol style="list-style-type: none"> At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift At least two registered children's nurses on duty at all times in each area At least one nurse per shift with appropriate level competences in paediatric critical care One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 or Level 2 critical care At least one nurse per shift with competences in care of children with tracheostomies and those requiring non-invasive or tracheostomy ventilation 	Y	
L2-208	<p>New Starters</p> <p>Nurses and non-registered health care staff without previous paediatric critical care experience should undertake:</p> <ol style="list-style-type: none"> A structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the PCC Unit (or in a higher level unit) A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months <p>Nurses and non-registered health care staff with previous paediatric critical care experience should complete local induction and a review of competence for their expected role.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
L2-209	<p>Other Staffing</p> <p>The following staff should be available:</p> <ul style="list-style-type: none"> a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit) c. Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit) d. Access to an educator for the training, education and continuing professional development of staff e. A discharge coordinator responsible for managing the discharge of children with complex care needs f. An educator for the training, education and continuing professional development of staff g. Pharmacist with competences in paediatric critical care (with time allocated at least 5/7 for work on the unit) h. Physiotherapist with competences in paediatric critical care (with time allocated at least 5/7 for work on the unit) i. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) j. Dietetic staff (with time allocated 5/7 for work on the unit) k. Staff with competences in psychological support with time allocated in their job plan for work with: <ul style="list-style-type: none"> i. families ii. staff 	Y	
L2-301	<p>Imaging Services</p> <p>24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Hospital should have arrangements for review of imaging by a paediatric radiologist.</p>	Y	
L2-302	<p>Co-located Services</p> <p>L2 PCC Units should be co-located with ENT services for the support of children with tracheostomies</p>	Y	

Ref	Standard	Met?	Reviewer's comments
L2-401	<p>Resuscitation Equipment</p> <p>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.</p>	Y	
L2-402	<p>'Grab Bag'</p> <p>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.</p>	Y	
L2-404	<p>Facilities</p> <p>Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care.</p>	Y	
L2-405	<p>Equipment</p> <p>Equipment, including disposables, should be appropriate for the usual number and age of children and the critical care interventions provided. Equipment should be checked in accordance with local policy.</p> <p>As a minimum, each bed space should have the capacity for:</p> <ol style="list-style-type: none"> ECG, respiration, pulse-oximetry and non-invasive blood pressure monitoring Transducing two pressure traces Temperature monitoring at two sites <p>These monitors should be available in a modular unit capable of integration with monitors used in the Emergency Department, theatres and portable monitoring systems</p>	Y	
L2-406	<p>'Point of Care' Testing</p> <p>'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.</p>	Y	
L2-502	<p>Paediatric Early Warning System</p> <p>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.</p>	Y	
L2-503	<p>Resuscitation and Stabilisation</p> <p>Hospital-Wide protocols for resuscitation and stabilisation should be in use, including:</p> <ol style="list-style-type: none"> Alerting the paediatric resuscitation team Arrangements for accessing support for difficult airway management Stabilisation and ongoing care Care of parents during the resuscitation of a child 	Y	

Ref	Standard	Met?	Reviewer's comments
L2-504	<p>Paediatric Advice</p> <p>Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.</p>	Y	
L2-505	<p>Clinical Guidelines</p> <p>The following clinical guidelines should be in use:</p> <ol style="list-style-type: none"> a. Treatment of all major conditions, including: <ol style="list-style-type: none"> i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) j. Rehabilitation after critical illness (if applicable) k. Acute non-invasive ventilation (CPAP and BiPAP) l. Tracheostomy care, including management of a tracheostomy emergency m. Care of children on long-term ventilation (tracheostomy and mask) 	N	<p>Paediatrics in Partnership guidelines were in place (PIP) but had not been complimented with information for use locally. Guidelines were not in place covering children undergoing surgery, rehabilitation after critical illness, acute non- invasive ventilation. The guidelines covering care of children on long term ventilation did not include information covering discharge and transfer.</p>

Ref	Standard	Met?	Reviewer's comments
L2-506	<p>PCC Transfer Guidelines</p> <p>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:</p> <ul style="list-style-type: none"> a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained 	Y	
L2-507	<p>In-hospital Transfer Guidelines</p> <p>Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.</p>	Y	
L2-508	<p>Inter-hospital Transfer Guidelines</p> <p>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:</p> <ul style="list-style-type: none"> a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer 	Y	

Ref	Standard	Met?	Reviewer's comments
L2-509	<p>Time-Critical Transfer Guidelines</p> <p>Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include:</p> <ul style="list-style-type: none"> a. Securing advice from the Specialist Paediatric Transport Service (QS L2-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS L2-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer 	Y	

Ref	Standard	Met?	Reviewer's comments
L2-601	<p>Operational Policy</p> <p>The service should have an operational policy covering at least:</p> <ul style="list-style-type: none"> a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for admission within four hours of the decision to admit g. Types of patient admitted h. Review by a senior clinician within four hours of admission i. Discussion with a consultant within four hours of admission j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff l. Discussion with a senior clinician prior to discharge m. Arrangements for discharge within four hours of the decision to discharge n. Arrangements for critical care 'outreach' to other wards within the hospital o. Discharge of children with tracheostomies: <ul style="list-style-type: none"> i. Suitability for discharge ii. Staffing and monitoring facilities that should be in place prior to discharge iii. Process for planning and agreement of discharge p. Discharge of children on long-term ventilation q. Agreed contribution to the network-wide training and CPD programme (QS N-206) 	N	The policy was not explicit about 'm, or n' but in practice staff were clear about arrangements.

Ref	Standard	Met?	Reviewer's comments
L2-702	<p>Data Collection</p> <p>The service should collect and submit:</p> <ul style="list-style-type: none"> a. Paediatric Intensive Care Audit Network (PICANet) data for submission to PICANet as soon as possible and no later than three months after discharge from the PCC Unit b. Paediatric Critical Care Minimum Data Set for submission to PICANet and SUS c. 'Quality Dashboard' data as recommended by the PCC CRG 	Y	'c' was not applicable
L2-704	<p>Key Performance Indicators</p> <p>Key performance indicators should be reviewed regularly with Hospital (or equivalent) management and with commissioners, including 'Quality Dashboard' data as recommended by the PCC CRG.</p>	Y	
L2-798	<p>Review and Learning</p> <p>The service should have appropriate multi-disciplinary arrangements for:</p> <ul style="list-style-type: none"> a. Review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses' b. Review and dissemination of published scientific evidence relating to paediatric critical care 	Y	

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