WM QRS West Midlands Quality Review Service

NHS

Review of Care of Critically Ill & Critically Injured Children - Emergency Department

The Royal Wolverhampton NHS Trust

Visit Date: 17th October 2017 Report Date: January 2018

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UKAS INSPECTION 8831

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INTRODUCTION

This report presents the findings of the review of care of the Critically Ill and Injured Child attending the Emergency Department at The Royal Wolverhampton NHS Trust that took place on 17th October 2017. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Care of Critically Ill and Critically Injured Children, Version 5.1 (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. The report also gives external assurance of the care that can be used as part of an organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team that reviewed the services at The Royal Wolverhampton NHS Trust (RWT). 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 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, 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 and a better patient and carer experience. It also aims to provide 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 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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WOLVERHAMPTON HEALTH ECONOMY

WOLVERHAMPTON URGENT CARE CENTRE

General Comments

The Wolverhampton Urgent Care Centre (WUCC) was operated by Vocare and commissioned by NHS Wolverhampton CCG. This service was situated on the first floor of the Urgent and Emergency Care Centre at New Cross Hospital and was not provided by The Royal Wolverhampton NHS Trust (RWT).

As part of the visit, reviewers discussed the pathway to and from the WUCC, visited the Emergency Department and Paediatric Assessment Unit and met with RWT staff. Reviewers did not meet with representatives from the WUCC or commissioners of the service. Following discussions with Trust staff about the urgent care pathway, reviewers had the following concerns: -

Concerns

1. **Paediatric Triage Process**

    a. Triage of patients to the WUCC did not always take place. If the RWT Emergency Department waiting room was busy, then patients would often choose to attend the WUCC instead. Timely triage was then dependant on staffing levels in the WUCC, and some patients would then be referred back to the RWT Emergency Department for assessment.

    b. The triage criteria for the WUCC were in the process of being revised to be condition-specific. Reviewers were concerned that paediatric early warning sign prompts were not included as part of the WUCC triage process. Early signs of deterioration might be missed as a result.

2. **Audit and Governance**

    Audit and governance arrangements between the WUCC and RWT were not well developed. Criteria for acceptance by the WUCC were not clearly understood. Delays in triage and the number of children then being sent to the Emergency Department for assessment were not clear and there was no forum for discussion between clinical staff representing the two services.

    Reviewers considered that the WUCC, the RWT, and the CCG clinical and service leads should work together to review the pathway, define the criteria for paediatric referrals and implement quality monitoring with all stakeholders.

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ROYAL WOLVERHAMPTON NHS TRUST

PAEDIATRIC EMERGENCY DEPARTMENT

General Comments and Achievements

Considerable progress had been made since the last visit in 2015.

A new Emergency Department had opened. This housed a specialist children's area consisting of two 'high care' cubicles, five children's cubicles, a triage area and a separate children's waiting area. The children's area was open from 8.00am to midnight, Monday to Friday. The Trust had plans to increase opening hours to 24 hours a day, seven days a week by April 2018.

The Trust had been successful in recruiting an additional 3.3wte paediatricians who sub-specialised in paediatric emergency medicine. Paediatric emergency medicine consultants were always present when the children's department was open and they provided cover in the main department for one shift each day at weekends. Advanced clinical practitioners and registered children's nurse staffing had also increased to a total of 9.17 wte. Staffing for the paediatric unit ranged between one and three registered children's nurses on duty, with higher numbers providing cover during times of peak demand.

Streaming to the WUCC was undertaken by the children's triage nurses who determined whether a patient was suitable for referral to it.

Since the last visit the number of patients attending the Paediatric Emergency Department had continued to increase from 22,362 in 2015 to 23,991 in 2016.

Many of the clinical processes and guidelines had been reviewed and improved.

Good Practice

1. The Trust had worked with schools to design a child-friendly mascot and other artwork that was displayed around the paediatric emergency care areas.
2. Children and young people admitted following pre-hospital cardiac arrest were cared for in 'Resus 7', away from the main paediatric area. The process had been designed by the Trust staff following a review of relevant research, with the aim of reducing additional stress to other children and their families. Reviewers considered this was an unusual but innovative approach to managing these emergency admissions.
3. The staff team were raising money through sponsored runs to provide suitable clothing for children who did not survive (rather than using hospital gowns).
4. A good range of information leaflets for children, young people and carers was available. The information was clear, concise and informative.

Immediate Risks: No immediate risks were identified

Concerns

1. **Advanced Paediatric Life Support (APLS) Training**

   None of the registered children's nurses had completed APLS training. Reviewers were told that a bid to secure funding for APLS training via 'learning beyond registration' had not been successful. Reviewers considered that, given the number of consultants who were APLS instructors, Paediatric Immediate Life Support (PLS) training could be provided at relatively little cost.

2. **Resuscitation equipment**

   a. Responsibility for the governance of equipment was not robust. The 'grab bag' containing transfer equipment was not sealed and records showing that the contents had been checked in accordance with

the Trust policy could not be located at the time reviewers visited the area. The lack of a seal on the bag and inconsistent checking of the contents was also identified during the last visit in 2015.

b. 'Resus 7' was both a paediatric and adult resuscitation room. The layout of the paediatric resuscitation equipment in this area was different from the layout in the other paediatric resuscitation areas. Reviewers were concerned that the different arrangements were potentially confusing and could cause delay in staff locating equipment during a paediatric resuscitation. Reviewers considered that reorganising the layout for both paediatric and adult resuscitation equipment in the resuscitation room would address the issue.

c. Permanent access to oxygen and suction equipment was not available in the triage area. Reviewers suggested that the availability of portable oxygen and suction equipment should be monitored.

3. **Urgent Care Centre Pathway**: see health economy section of the report

Further Consideration

1. The number of children's trained nurses was insufficient to ensure a registered children's nurse was on duty at all times when the paediatric emergency area was closed or when a paediatric nurse had to attend a child in 'Resus 7' in the Adult Emergency Department. Reviewers noted that this was likely to be addressed by April 2018.
2. It was unclear whether all the adult nurses who cared for children in the absence of a registered children's nurse had completed training on use of the Paediatric Early Warning Score (PEWS) and escalation processes. Data on PEWS training was not accessible to the reviewers at the time of the visit.
3. Although documentation had improved considerably since the last visit, reviewers commented on the following:

   a. Many of the patient and family information leaflets had review dates that had expired. Reviewers suggested that the Trust should review whether the leaflets required updating and whether a review date (in addition to a publication date) was necessary.

   b. The draft trauma guidance did not yet cover all the requirements of the relevant Quality Standard.

   c. The paediatric escalation policy that was provided was dated 2013 and would benefit from being updated.

4. The department did not have access to a play specialist. Reviewers considered that it may be helpful to ensure staff were trained in the use of distraction and supportive therapies and equipment.
5. Opportunities for review and learning could be improved further by: -

   a. The development of an operational policy for the children's emergency department.

   b. Multidisciplinary discussion of positive feedback, complaints, incidents and near misses and agreeing appropriate actions.

   c. Developing mechanisms for the ongoing involvement of children and parents in the organisation of the service.

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Helen Cope	Lead Nurse Deteriorating Patient and Resuscitation Team Team Leader Nurse Education Team	Sandwell & West Birmingham Hospitals NHS Trust
Dr James Davidson	Consultant in Emergency Medicine and Associate Medical Director	University Hospitals Coventry & Warwickshire NHS Trust
Sue Ellis	Lead Nurse Paediatrics & Neonatology	University Hospitals Coventry & Warwickshire NHS Trust
Paula Lane	Lead Nurse Paediatric Emergency	Heart of England NHS Foundation Trust
Jane Williams	Patient Representative	

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 below.

Service	Number of Applicable QS	Number of QS Met	% met
Trust-wide	9	8	89%
Emergency Department for Children	42	32	76%
Total	**51**	**40**	**78%**

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TRUST-WIDE

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-201	**Board-Level Lead for Children** A Board-level lead for children's services should be identified.	Y	
PC-202	**Clinical Leads** The Board-level lead for children's services should ensure that the following leads for the care of children have been identified: a. Lead consultants and nurses for each of the areas where children may be critically ill (QS PM-201) b. Lead consultant for paediatric critical care c. Lead consultant for surgery in children (if applicable) d. Lead consultant for trauma in children (if applicable) e. Lead anaesthetist for children (QS PG-201) f. Lead anaesthetist for paediatric critical care (QS PG-202) g. Lead GICU consultant for children (QS PG-203) (if applicable) h. Lead consultant/s and lead nurse/s for the Specialist Paediatric Transport Service (QS PT-201) (if applicable) i. Lead consultant and lead nurse and for safeguarding children j. Lead allied health professional for the care of critically ill children	Y	
PC-203	**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 Lead for children's services (QS PC-201). The relationship of the group to the Trust's mechanisms for safeguarding children and clinical governance issues relating to children should be clear.	Y	The Critically Ill Children's group was chaired by a paediatrician and reported to the Trust lead.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-204	**Paediatric Resuscitation Team** A paediatric resuscitation team should be immediately available at all times, comprising at least three people: a. 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) b. A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences c. An anaesthetist or other doctor with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management	Y	
PC-205	**Consultant Anaesthetist 24 Hour Cover** 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.	Y	
PC-206	**Other Clinical Areas** 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.	N/A	Only the Paediatric Assessment Unit was visited as part of the visit.
PC-401	**Paediatric Resuscitation Team – Equipment** The paediatric resuscitation team should have immediate access to appropriate drugs and equipment which are checked in accordance with local policy.	Y	See main report about the responsibility for equipment checking and the layout of equipment in 'Resus 7'
PC-501	**Resuscitation and Stabilisation** Protocols should be in use covering resuscitation and stabilisation, including: 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	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PC-502	**Surgery and Anaesthesia Criteria** Trust-Wide guidelines on criteria for surgery and anaesthesia for children should be in use covering: a. Elective and emergency surgical procedures undertaken on children of different ages b. Day case criteria c. Non-surgical procedures requiring anaesthesia or conscious sedation	N/A	This QS was not reviewed as part of the visit.
PC-598	**Trust-Wide Guidelines** The following Trust-Wide guidelines should be in use: a. Consent b. Organ and tissue donation c. Palliative care d. Bereavement e. Staff acting outside their area of competence covering: i. Exceptional circumstances when this may occur ii. Staff responsibilities iii. Reporting of event as an untoward clinical incident iv. Support for staff	N	It was not clear if the policy for Staff acting outside their area of competence covered all the requirements of the QS.
PC-602	**Paediatric Critical Care Operational Delivery Network Involvement** 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.	Y	

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EMERGENCY DEPARTMENT FOR CHILDREN

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-101	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities.	Y	
PM-102	**Parental Access and Involvement** Parents should: a. 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 b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child	Y	
PM-103	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available.	Y	A good range of information was available for children and young people. However, a number of leaflets had exceeded their review dates.
PM-104	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Relevant support groups and voluntary organisations	Y	A range of information was available in written and electronic forms. Information signposting families to psychological and financial support, local support groups and voluntary organisations was dependent on staff giving verbal information. Reviewers considered the process to ensure families received information about these services could be more robust.
PM-196	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-197	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services	Y	However, signage to the information centre would benefit from being much more visible from both the main entrance and the Emergency Department.
PM-199	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families	Y	A range of mechanisms for receiving feedback was in place, such as text messaging and patient feedback forms, and changes to the waiting area had been made following feedback. Local children had also contributed to the artwork in the new unit. Reviewers considered that, as part of the development of the service, there was more potential to involve children and families in the organisation of the service. Increasing communication in conjunction with Trust-wide mechanisms such as the Patient Advisory Liaison Service and the Information Centre may be helpful.
PM-201	**Lead Consultant and Lead Nurse** 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.	Y	
PM-202	**Consultant Staffing** 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 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	Y	Eleven out of the fifteen consultants had advanced paediatric resuscitation and life support competences and five of the consultants were instructors. All consultants had completed advanced trauma life support (ATLS) training.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-203	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: 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 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.	Y	
PM-206	**Competence Framework and Training Plan – Staff Providing Bedside Care** 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: 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 PM-208) and expected input to the paediatric resuscitation team (QS PC-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	The service had insufficient nursing staff with advanced paediatric resuscitation and life support competences. Reviewers were told that a bid to access funding via 'learning beyond registration' for the course had not been successful. The Royal College of Nursing competence framework was in use but some of the staff who met the reviewing team were not aware of this. All trained staff did have basic life support (BLS) competences and 80% of untrained staff had undertaken BLS training.'Training Boards' were on display, which allowed staff to easily book onto any relevant training, and a new induction programme had been implemented.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-207	**Staffing Levels: Bedside Care** 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. The following minimum nurse staffing levels should be achieved: 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	N	At least one nurse on each shift with APLS competences was not yet in place. Not all night shifts were covered with a paediatric nurse, but arrangements were in place to obtain cover from the ward. From April 2018 it was expected that 24/7 cover would be achievable.
PM-209	**Other Staffing** The following staff should be available: 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)	N	Staff were not trained in distraction therapy. However, a range of distraction and stimulation tools were available in High Care 2.
PE-211	**ED Liaison Paediatrician** A nominated paediatric consultant should be responsible for liaison with the nominated Emergency Department consultant (QS PM-201).	Y	
PE-212	**ED Sub-speciality Trained Consultant** Emergency Departments seeing 16,000 or more child attendances per year should have a consultant with sub-specialty training in paediatric emergency medicine.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-213	**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	
PE-214	**Trauma Team** Emergency Departments receiving children with trauma should have a Trauma Team immediately available at all times, including: a. Team Leader b. Emergency Department senior decision-maker c. Clinician with Level 1 RCPCH competences d. General Surgeon e. Orthopaedic Surgeon f. Anaesthetist with competences in advanced airway management (QS PC-204)	Y	The process for receiving children with trauma had improved since the last visit in 2015, and the Paediatric Major Trauma Guidelines had been revised for use locally.
PM-298	**Safeguarding Training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role, as agreed by the Trust and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the Trust and local Safeguarding Board	Y	Staff had completed level two safeguarding training as mandated and appropriate to their role. In addition, 57% of clinical staff had completed safeguarding training to level three. Staff who met the reviewing team were clear about the process and their responsibilities.
PM-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	
PM-301	**Imaging Services** 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 Trust should have arrangements for review of imaging by a paediatric radiologist.	Y	
PM-401	**Resuscitation Equipment** An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.	Y	See main report about the responsibility for equipment checking and the layout of equipment in 'Resus 7'.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-402	**Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.	N	A 'grab bag' was available but was not sealed, and the records for checking were not available to reviewers when they visited the area. From discussions with staff it was not clear who had responsibility for checking the equipment.
PE-403	**Facilities for Children** At least one clinical cubicle or trolley space for every 5,000 annual child attendances should be dedicated to the care of children.	Y	
PM-406	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.	Y	Reviewers were impressed that there was a blood gas analyser specifically for the children's area.
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 for full assessment exceed 15 minutes.	Y	
PM-502	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.	Y	However, it was not clear if adult trained nurses who covered the paediatric areas were trained in the use of PEWS and the escalation process.
PM-503	**Resuscitation and Stabilisation** Trust-Wide protocols for resuscitation and stabilisation should be in use, including: 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	
PM-504	**Paediatric Advice** 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.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-505	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: 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	Y	
PM-506	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical informationb. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Servicec. 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	The policy was in the process of being revised.
PM-507	**In-hospital Transfer Guidelines** 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.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-508	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:a. Types of patients transferredb. Composition and expected competences of the escort teamc. Drugs and equipment requiredd. Restraint of children, equipment and staff during transfere. Monitoring during transfer	Y	The policy had been due for review in 2016.
PM-509	**Time-Critical Transfer Guidelines** 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: a. Securing advice from the Specialist Paediatric Transport Service (QS PM-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 PM-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	N	The policy did not cover the process for department staff having to undertake a time-critical transfer. All other aspects of the QS were met.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-510	**Trauma Guidelines** Guidelines on the care of children with trauma should be in use covering: a. Handling calls received on the dedicated trauma phone b. Alerting and activating the Trauma Team (QS PE-214) c. Handover from the pre-hospital team to the Trauma Team lead d. Responsibilities of members of the Trauma Team, including responsibility for: i. Liaison with families ii. Calling all relevant consultants iii. Safeguarding children and vulnerable adults e. Involvement of a paediatric neurosurgeon 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. Specialist paediatric surgery vi. Other specialist surgery g. Handover of children no longer needing the care of the Trauma Team h. Completing standardised documentation i. Major incidents	Y	Trauma guidelines were on the intranet and a revised version was in the process of being ratified.
PE-511	**Trauma Clinical Guidelines** Guidelines should be in use covering the care of children with trauma, including: a. Immediate airway management b. Haemorrhage control and massive transfusion c. Chest drain insertion	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-512	**Trauma Imaging Guidelines** Guidelines on imaging of children with trauma should be in use covering at least: a. Imaging modalities and indications b. Liaison with a radiologist to agree an imaging plan c. Timescales for undertaking imaging d. Indications and arrangements for review of imaging by a neuro-radiologist e. imescales for provisional and final reporting f. Electronic transmission of images g. Responsibilities for recording receipt of imaging reports h. Monitoring achievement of expected timescales: i. T scanning within 30 minutes of arrival ii. Provisional report issued within one hour iii. Full report issued within 12 hours i. Communication of any significant variations between the provisional and final reporting	N	The West Midlands Trauma guidelines were in the process of being amended for use locally.
PM-598	**Implementation of Trust Guidelines** Staff should be aware of and following Trust guidelines (QS PC-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence	N	It was not clear if the policy for Staff acting outside their area of competence covered all the requirements of the QS.
PM-601	**Operational Policy** The service should have an operational policy covering at least: 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	N	An operational policy specific to the paediatric emergency department was not yet in place. In practice arrangements were in place.

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PE-602	**Urgent Care Centres** If the Trust's services include an Urgent Care Centre, this Centre should have: a. At least one clinician with advanced paediatric resuscitation and life support competences is available on site at all times the service is open b. Appropriate drugs and equipment for a paediatric resuscitation, including a defibrillator, oxygen and suction c. Guidelines in use in the event of a critically ill child, or potentially critically ill child, presenting. The guidelines should include transfer to an appropriate paediatric unit	N/A	See main report.
PE-603	**Emergency Centres 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 c. Have arrangements for accessing paediatric medical advice and appropriate anaesthetic input to the care of a child	N/A	
PE-701	**Data Collection** The service should collect and submit Trauma Audit Research Network data and should review their performance compared with other units on a regular basis.	Y	TARN data submitted.
PM-703	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS PM-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	N	Audits were undertaken, but not for 'c'.
PM-704	**Key Performance Indicators** Key performance indicators should be reviewed regularly with Trust (or equivalent) management and with commissioners.	Y	

Ref	Quality Standards	Met? Y/N	Reviewer Comments
PM-798	**Review and Learning** The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.	Y	
PM-799	**Document Control** All policies, procedures and guidelines and should comply with Trust document control procedures.	N	Document control had improved considerably since the last visit in 2015, but some documents seen were out of date.

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