WM QRS West Midlands Quality Review Service

NHS

West Midlands Paediatric Critical Care Network

# Care of Critically Ill & Critically Injured Children Quality Review Visit

## South Warwickshire NHS Foundation Trust

Visit Date: 24th September 2018 Report Date: November 2018

*Images courtesy of NHS Photo Library and Sandwell and West Birmingham Hospitals NHS Trust*

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# INTRODUCTION

This short report presents the findings of the review of Critically Ill and Injured Children that took place on 24th September 2018. The review visits were 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 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 outlines 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 and review the pathway for critically ill children attending the Emergency Department and Children's assessment units 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 what plans or requirements 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 these visits. 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 visits consisted of a half day visit whereby 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 previous Critically Ill and 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 will include the Trust and WMQRS response to any actions taken to mitigate against the risk. Appendix 1 lists the visiting team that reviewed the services at South Warwickshire Hospital NHS Foundation Trust**.** Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

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

- South Warwickshire NHS Foundation Trust
- NHS South Warwickshire Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS South Warwickshire Clinical Commissioning Group.

## ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS 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 South Warwickshire NHS Foundation Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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# Care of the Critically Ill and Critically Injured Children

## Trust-wide

**General Comments and Achievements**

This review looked at the care of critically ill and critically injured children in the Emergency Department (ED), and inpatient and high dependency care at the Trust. Reviewers found good team-working within and between departments, with a strong commitment to working together to provide high quality care for children.

Some comments in the Trust-wide section of this report apply to more than one service and are not duplicated in other areas of the report.

**Good Practice**

1. The child and adolescent mental health service (CAMHS) pathway was very clear about roles and responsibilities, and staff had also undertaken de-escalation training so that they could provide better support for children in distress.
2. Reviewers were impressed with the appointment of a CAMHS liaison sister who had commenced in post on the day of the visit, and who would provide advice and support for children with mental health issues who attended the ED or who were admitted to the inpatient ward.

   The difficult airway trolley was very well organised, clearly labelled and equipped, to enable provision of the different levels of support required in caring for a child with a difficult airway. A good process for checking and auditing the equipment was also in place

**Immediate risk [1]**

1. **Availability of staff with appropriate resuscitation training**

   From the evidence provided to the reviewers at the time of the visit not all staff caring for children at the Trust had appropriate competences in advanced paediatric resuscitation and life support and basic paediatric life support. Evidence on up to date training for some other staff groups was not available to reviewers. Reviewers considered that the combination of a) lack of training and b) limited evidence meant that they could not be assured that sufficient staff with appropriate competences to initiate and lead a paediatric resuscitation would always be available, especially out of hours.

   a. Reviewers were told that most of the ED consultants were advanced paediatric resuscitation and life support instructors, but from the evidence seen, two out of the ten consultants were not up to date. Reviewers were told that because revalidation for instructors was carried out externally and the

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[1] **Trust Response:** The Learning and Development department have been tasked with including the training compliance for all levels of paediatric life support for all relevant staff, on the monthly training reports, to ensure visibility of compliance rates at all levels of management within the organisation. The L & D team are currently liaising with the relevant departments to understand the required staff groups needing to undertake advanced or immediate resuscitation and life support training, at which level, and expiry times. It is anticipated that the reports will be available no later than the end of Q3. These reports will be accessible to the local departments each month. I am able to confirm that at the time of your visit 80% of Emergency Department Consultants held valid advanced paediatric resuscitation and life support training compliance. The outstanding 2 Consultants have courses reserved in November. E D Middle Grade compliance will be included on the aforementioned reports for all substantive staff. Arrangements have been put in to place to ensure locum middle grade doctors have PLS qualification prior to any booking being made. Compliance rate in the substantive staff group is 100% and evidence of this will be provided with the action plan. Nurse PLS training compliance is being prioritised within ED and Macgregor ward and external support is being sought to increase the availability of courses locally. The Paediatric Consultant has a APLS course booked in December. All anaesthetic consultants on the on-call rota are competent to intubate and manage a resuscitation. Competence is maintained through in-house simulation training, a requirement to complete paediatric specific CPD, and rotating to paediatric theatre lists.

**WMQRS Response** With these assurances we would agree that the actions as described, once fully implemented, would address the immediate risk.

information was held by the individual clinician, the information as to whether staff were up to date was not collected at service level.

b. Data were not available to show whether ED middle grade clinicians all had up to date advanced paediatric resuscitation and life support competences.

c. Data showed that only 17 out of 55 nurses in the ED had up to date basic paediatric resuscitation and life support competences.

d. From the evidence seen, 14 out of 35 anaesthetists had advanced resuscitation and life support training, but it was not clear whether all the anaesthetists on the on-call rota were competent in the intubation of young children and in leading a paediatric resuscitation.

e. One out of the seven paediatric consultants did not have up to date advanced resuscitation and life support competences, though since the visit it was confirmed that the consultant was booked to attend a course.

f. Two paediatric middle grade clinicians did not have up to date advanced paediatric resuscitation and life support competences, but reviewers were told that they were booked to attend training in October and November 2018.

g. On the paediatric ward a nurse with advanced paediatric resuscitation and life support competences was not on duty at all times, as only two nurses had advanced paediatric resuscitation and life support training (advanced paediatric resuscitation and life support training had expired two years ago for one other lead nurse). However, some staff had completed paediatric immediate life support training. Ten out of twenty-five staff did not have up to date basic paediatric life support. Reviewers were particularly concerned because the ward staff were often required to support the ED at times of peak demand, which had the potential to leave the ward area with insufficient staff cover.

**Concerns**

1 **Transfer protocols**

Protocols for inter-hospital transfer and for time critical transfer of children and young people needing high dependency care were not robust.

a. The time critical policy was part of the Trust's Management of the Critically Ill Child guidelines but did not include detail about roles, responsibilities and indemnity arrangements for Trust staff in the emergency transfer of children.

b. The inter-hospital transfer policy for those children who needed to be transferred to level 2 care elsewhere in the region listed conditions rather than giving details of who to contact if Kids Intensive Care and Decision Support team (KIDS) were unable to transfer the child. In practice, staff would contact the West Midlands Ambulance Service.

2 **Guidelines and policies**

At the time of the visit, guidelines and policies were on the intranet, but the Trust was in the process of commissioning the use of the Paediatric in Partnership guidelines (PIP). Reviewers were shown copies of guidance that was out of date, and different versions of some guidelines were all in circulation, causing confusion for staff. Reviewers were told that a review of all guidance was taking place and the Trust was in the process of reviewing the latest version of the PIP guidelines which were almost ready to be implemented.

**Further Consideration**

1. Some of the lead team for children's services at the Trust were either new in post or in interim posts; the lead nurse on Macgregor Ward had been interim for over one year, the consultant lead in the ED was interim and the matron for the ED was new in post. Reviewers commented that operational staff would benefit from certainty and consistency of those in leadership roles.

## Children's Emergency Department

**General Comments and Achievements**

Staff in the ED were working hard to meet the needs of children. The ED had separate waiting, assessment and treatment areas for children. Working relationships with paediatric services were good and mutually supportive. A paediatric skills competency framework for adult registered nurses was in place.

**Good Practice**

1. Reviewers were impressed with the vision of the new matron, who clearly had plans for improving the care of children attending the ED and had already started to embed training in the care of the critically ill child and in recognising deterioration.
2. See also Trust-wide section of the report (under Good Practice).

**Immediate Risks: See Trust-wide section of the report (under Immediate Risks)**

**Concerns**

1. **Children's Trained Nurses**

   The ED was not able to meet the expected standards of one children's trained nurse in the department at all times. Cover by a registered children's nurse was from 9.30am to 10pm daily. Outside these times, children were cared for by adult ED nurses who had competences relevant to their role in caring for children.
2. See Trust-wide section of the report (under Concerns).

**Further Consideration**

1. Liaison for children with mental health needs was only available four days a week. It was not clear if the new CAMHS liaison sister would enable cover on a daily basis.

## Inpatient Ward and Paediatric High Dependency Care

**General Comments and Achievements**

Macgregor Ward was an 18-bedded inpatient ward with seven cubicles. Paediatric services were provided by a well-organised team. Seven consultants ran a 1:7 rota, and consultants were available from 9am to 5pm weekdays and for consultant ward rounds at weekends. The Trust had recently appointed an eighth consultant who was not yet in post, and had plans to appoint one further consultant paediatrician.

**Good Practice**

1. See Trust-wide section of the report (under Good Practice).
2. The treatment room was very well-organised and equipped for the stabilisation of children prior to transfer (see also Further Consideration section below).
3. A good training needs analysis had been undertaken, which was very comprehensive. Consideration had been given to existing training needs as well as to the staff training required to enable further development of the service.

**Immediate Risks:** See Trust-wide section of the report (under Immediate Risks)

**Concerns**

1. **Paediatric Early Warning System (PEWS)**

   A system was in use, but the reviewers were unsure whether the escalation and de-escalation process was being followed at the time of the visit. In a set of clinical records seen, a child had 'scored four' three times but had only been seen once by a junior member of the medical team and had not been escalated further.

Documentation showed that the timeframe for observation had been de-escalated to four hours with no explanation for the decision, as the child was still prescribed nebulised medication every 2 hours. Reviewers considered that the team should undertake further audit of the PEWS policy to check whether the escalation and de-escalation process had been fully implemented and understood by staff.

2. **Designated HDU facility**

   Paediatric critical care was not provided in a designated area that was distinct from the area for children needing general paediatric care. The ward had 'mobile' HDU beds, which required equipment to be taken to the bed areas.

3. See also Trust-wide section (under Concerns).

**Further Consideration**

1. Those children who required stabilising and transfer were cared for in the treatment room (see Good Practice section above about the organisation of this area). However, on the day of the visit the area was being used as clinic space, with toys on the bed space, and reviewers considered that this was not the most appropriate area to see children. It would be difficult to use this area if a child required resuscitation and stabilisation.

2. Reviewers did not see a structured plan for achieving competences that were not yet in place (for example resuscitation competences) and that included timeframes for achieving competences and how competences would be maintained.

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# Appendix 1 Membership of Visiting Team

| Visiting Team | | |
|---|---|---|
| Emma Bull | KIDSNTS Lead Nurse, KIDS Intensive Care and Decision Support | Birmingham Women's and Children's NHS Foundation Trust |
| Ally Davies | Network Lead/BWC Transformation Manager | Birmingham Women's and Children's NHS Foundation Trust |
| Aimee Haynes | Network Governance Administrator | KIDS/NTS Retrieval Service; Birmingham Women's and Children's NHS Foundation Trust |
| Dr Wasiullah Shinwari | Consultant Paediatrician | Worcestershire Acute Hospitals NHS Trust |
| Dr Intikhab Zafurallah | Consultant Paediatric Intensivist | KIDS/NTS Retrieval Service; Birmingham Women's and Children's NHS Foundation 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 |
|---|---|---|---|
| Hospital-wide | 10 | 9 | 90 |
| Emergency Department | 20 | 12 | 60 |
| Integrated IP & L1PCCU | 29 | 17 | 59 |
| **Health Economy** | **59** | **38** | **64** |

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## HOSPITAL-WIDE

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| HW-201 | **Board-Level Lead for Children**<br><br>A Board-level lead for children's services should be identified. | Y | |
| HW-202 | **Clinical Leads**<br><br>The Board-level lead for children's services should ensure that the following leads for the care of children have been identified:<br>a. Lead consultants and nurses for each of the areas where children may be critically ill (QS **-201)<br>b. Lead consultant for paediatric critical care<br>c. Lead consultant for surgery in children (if applicable)<br>d. Lead consultant for trauma in children (if applicable)<br>e. Lead anaesthetist for children (QS A-201)<br>f. Lead anaesthetist for paediatric critical care (QS A-202)<br>g. Lead GICU consultant for children (QS A-203) (if applicable)<br>h. Lead consultant/s and lead nurse/s for the Specialist Paediatric Transport Service (QS T-201) (if applicable)<br>i. Lead consultant and lead nurse and for safeguarding children<br>j. Lead allied health professional for the care of critically ill children | Y | |
| HW-203 | **Hospital Wide Group**<br><br>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.<br>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. | Y | |

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| HW-204 | **Paediatric Resuscitation Team**<br><br>A paediatric resuscitation team should be immediately available at all times, comprising at least three people:<br>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)<br>b. A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences<br>An anaesthetist, or other practitioner, with up to date competences in advanced paediatric resuscitation and life support and advanced airway management | Y | |
| HW-205 | **Consultant Anaesthetist 24 Hour Cover**<br><br>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 | |
| HW-206 | **Other Clinical Areas**<br><br>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. | Y | |
| HW-401 | **Paediatric Resuscitation Team – Equipment**<br><br>The paediatric resuscitation team should have immediate access to appropriate drugs and equipment which are checked in accordance with local policy. | Y | |
| HW-501 | **Resuscitation and Stabilisation**<br><br>Protocols should be in use covering resuscitation and stabilisation, including:<br>a. Alerting the paediatric resuscitation team<br>b. Arrangements for accessing support for difficult airway management<br>c. Stabilisation and ongoing care<br>d. Care of parents during the resuscitation of a child | N | The policy was not specific about the care of parents during the resuscitation but in practice processes were in place to support parents. |

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| HW-598 | **Trust-Wide Guidelines**<br><br>The following Trust-Wide guidelines should be in use:<br>a. Consent<br>b. Organ and tissue donation<br>c. Palliative care<br>d. Bereavement<br>e. Staff acting outside their area of competence covering:<br>f. Exceptional circumstances when this may occur<br>g. Staff responsibilities<br>h. Reporting of event as an untoward clinical incident<br>i. Support for staff | Y | |
| HW-602 | **Paediatric Critical Care Operational Delivery Network Involvement**<br><br>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

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| ED-201 | **Lead Consultant and Lead Nurse**<br><br>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 | |
| ED-202 | **Consultant Staffing**<br><br>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<br>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 | N | Reviewers were told that most of the Emergency Department Consultants were advanced paediatric resuscitation and life support instructors, but from the evidence seen two out of the ten consultants did not have up to date competences. See also main report. |
| ED-203 | **'Middle Grade' Clinician**<br><br>A 'middle grade' clinician with the following competences should be immediately available at all times:<br>a. Advanced paediatric resuscitation and life support<br>b. Assessment of the ill child and recognition of serious illness and injury<br>c. Initiation of appropriate immediate treatment<br>d. Prescribing and administering resuscitation and other appropriate drugs<br>e. Provision of appropriate pain management<br>f. Effective communication with children and their families<br>g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant<br>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. | N | Evidence of compliance with this QS was not available to Reviewers at the time of the visit. |

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| ED-206 | **Competence Framework and Training Plan – Staff Providing Bedside Care**<br><br>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:<br>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)<br>b. Care and rehabilitation of children with trauma (if applicable)<br>c. Care of children needing surgery (if applicable)<br>d. Use of equipment as expected for their role<br>e. Care of children with acute mental health problems | N | Not all staff had basic paediatric resuscitation and life support competences (17 out of 55 nurses).<br>A skill competency framework for adult registered nurses was in place. |
| ED-207 | **Staffing Levels: Bedside Care**<br><br>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.<br>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.<br>The following minimum nurse staffing levels should be achieved:<br>a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift<br>b. At least one registered children's nurses on duty at all times in each area | N | Cover by a registered children's nurse was from 9.30 am to 10pm daily outside of these times children were cared for by adult ED nurses. |

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| ED-209 | **Other Staffing**<br><br>The following staff should be available:<br>a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7)<br>b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7)<br>c. Access to dietetic service (at least 5/7)<br>d. Access to a liaison health worker for children with mental health needs (7/7)<br>e. Access to staff with competences in psychological support (at least 5/7) | N | Liaison for children with mental health needs was only available on week days. A CAMHS liaison Sister had commenced in post on the day of the visit who would be able to provide additional support. |
| ED-211 | **ED Liaison Paediatrician**<br><br>A nominated paediatric consultant should be responsible for liaison with the nominated Emergency Department consultant (QS ED-201). | Y | |
| ED-212 | **ED Sub-speciality Trained Consultant**<br><br>Emergency Departments seeing 16,000 or more child attendances per year should have a consultant with sub-specialty training in paediatric emergency medicine. | N/A | The ED saw less than 16,000 children per year. |
| ED-301 | **Imaging Services**<br><br>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. | Y | However, the CT scan was a long way from ED if staff had to transport a ventilated child. |
| ED-401 | **Resuscitation Equipment**<br><br>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 | |
| ED-402 | **Grab Bag'**<br><br>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. | Y | The grab bag was for adults and children. |

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| ED-501 | **Initial Assessment**<br><br>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 | Initial assessment was undertaken within 10 minutes of arrival. |
| ED-502 | **Paediatric Early Warning System**<br><br>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 | |
| ED-503 | **Resuscitation and Stabilisation**<br><br>Hospital-Wide protocols for resuscitation and stabilisation should be in use, including:<br>a. Alerting the paediatric resuscitation team<br>b. Arrangements for accessing support for difficult airway management<br>c. Stabilisation and ongoing care<br>d. Care of parents during the resuscitation of a child | Y | |
| ED-504 | **Paediatric Advice**<br><br>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 | |
| ED-505 | **Clinical Guidelines**<br><br>The following clinical guidelines should be in use:<br>a. Treatment of all major conditions, including:<br>i. acute respiratory failure (including bronchiolitis and asthma)<br>ii. sepsis (including septic shock and meningococcal infection)<br>iii. management of diabetic ketoacidosis<br>iv. seizures and status epilepticus<br>v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable)<br>vi. burns and scalds<br>vii. cardiac arrhythmia<br>viii. upper airway obstruction<br>b. Management of acutely distressed children, including use of restraint<br>c. Drug administration and medicines management<br>d. Pain management<br>e. Procedural sedation and analgesia<br>f. Infection control and antibiotic prescribing<br>g. Tissue viability, including extravasation | N | Different version of guidance was accessible which was causing confusion for staff. Some guidance was on the intranet and some in the Paediatrics in Partnership (PIP) guidelines from 2017 on the ward. A review of guidance was taking place and the Trust was in the process of implementing PIP guidelines which were being checked for use locally. |

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| ED-506 | **PCC Transfer Guidelines**<br><br>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:<br>a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information<br>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<br>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 | N | Guidance was due for review in December 2017. |
| ED-507 | **In-hospital Transfer Guidelines**<br><br>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 | |
| ED-508 | **Inter-hospital Transfer Guidelines**<br><br>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:<br>a. Types of patients transferred<br>b. Composition and expected competences of the escort team<br>c. Drugs and equipment required<br>d. Restraint of children, equipment and staff during transfer<br>e. Monitoring during transfer | Y | Though see main report. |

| Ref | Standard | Met? | Reviewer's comments |
|---|---|---|---|
| ED-509 | **Time-Critical Transfer Guidelines**<br><br>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:<br>a. Securing advice from the Specialist Paediatric Transport Service (QS ED-506)<br>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<br>c. Indemnity for escort team<br>d. Availability of drugs and equipment, checked in accordance with local policy (QS ED-402)<br>e. Arrangements for emergency transport with a local ambulance service and the air ambulance<br>f. Arrangements for ensuring restraint of children, equipment and staff during transfer | N | The policy for time critical transfers was included as part of the Management of the Critical Ill child, but did not cover all the requirements of the QS. |
| ED-798 | **Review and Learning**<br><br>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 | |

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## INTEGRATED IN-PATIENTS & L1 PAEDIATRIC CRITICAL CARE

| Ref | Standard | Met? | Reviewer's comments |
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| L1-101 | **Child-friendly Environment**<br><br>Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities. | Y | |
| L1-102 | **Parental Access and Involvement**<br><br>Parents should:<br>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<br>b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly<br>c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child | Y | |
| L1-201 | **Lead Consultant and Lead Nurse**<br><br>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 | |
| L1-202 | **Consultant Staffing**<br><br>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<br>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 | A business case had been agreed to increase the number of consultants to nine. |

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| L1-203 | **'Middle Grade' Clinician**<br><br>A 'middle grade' clinician with the following competences should be immediately available at all times:<br>a. Advanced paediatric resuscitation and life support<br>b. Assessment of the ill child and recognition of serious illness and injury<br>c. Initiation of appropriate immediate treatment<br>d. Prescribing and administering resuscitation and other appropriate drugs<br>e. Provision of appropriate pain management<br>f. Effective communication with children and their families<br>g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant<br><br>A clinician with at least Level 1 RCPCH (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. | N | Both middle grade clinicians were booked to attend APLS training in October and November 2018. |
| L1-205 | **Medical Staff: Continuity of Care**<br><br>Consultant rotas should be organised to give reasonable continuity of care. | Y | The Consultant rota was not available for reviewers to consider at the time of the visit. Reviewers were told by the team that consultant of the week approach was in place to providing 24/7 consultant cover. |

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| L1-206 | **Competence Framework and Training Plan – Staff Providing Bedside Care**<br><br>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:<br>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 L1-208) and expected input to the paediatric resuscitation team (QS HW-204)<br>b. Care and rehabilitation of children with trauma (if applicable)<br>c. Care of children needing surgery (if applicable)<br>d. Use of equipment as expected for their role<br>e. Care of children with acute mental health problems<br>f. 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 | Not every shift had cover by a nurse with advanced paediatric resuscitation and life support competences. Four /25 staff had completed High Dependency training. 10/25 staff did not have basic paediatric resuscitation and life support competences (including the seven new starters). The ward had good support from mental health services and training had been provided for staff on the care of children with acute mental health problems. |
| L1-207 | **Staffing Levels: Bedside Care**<br><br>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.<br>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.<br>The following minimum nurse staffing levels should be achieved:<br>a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift<br>b. At least two registered children's nurses on duty at all times in each area<br>c. At least one nurse per shift with appropriate level competences in paediatric critical care<br>d. One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 critical care | N | The ward had insufficient nurses with up to date advanced paediatric resuscitation and life support competences on each shift.<br>Four out of 25 staff had completed training in HDU care. |

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| L1-208 | **New Starters**<br><br>Nurses and non-registered health care staff without previous paediatric critical care experience should undertake:<br>a. 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)<br>b. A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months<br>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. | N | At the time of the visit, some new starters had not completed basic paediatric resuscitation and life support training. |
| L1-209 | **Other Staffing**<br><br>The following staff should be available:<br>a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7)<br>b. Access to a liaison health worker for children with mental health needs (7/7)<br>c. Access to staff with competences in psychological support (at least 5/7)<br>d. Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit)<br>e. Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit)<br>f. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7)<br>g. Access to dietetic service (at least 5/7)<br>h. Access to an educator for the training, education and continuing professional development of staff | N | Staff providing support for play, mental stimulation and distraction during procedures were not available daily. Liaison for children with mental health needs was only available on week days. A CAMHS Liaison Sister had commenced in post on the day of the visit who would be able to provide additional support. |
| L1-301 | **Imaging Services**<br><br>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. | Y | |

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| L1-401 | **Resuscitation Equipment**<br><br>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 | |
| L1-402 | **'Grab Bag'**<br><br>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. | N | On the day of the visit the grab bag was not sealed and had been moved behind cleaning equipment so was not easily accessible. |
| L1-404 | **Facilities**<br><br>Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care. | N | See main report about designated HDU facilities and use of the treatment room. |
| L1-405 | **Equipment**<br><br>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. | Y | |
| L1-406 | **'Point of Care' Testing**<br><br>'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available. | Y | |
| IP-501 | **Initial Assessment**<br><br>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 | A triage protocol in place on ward for patients who were admitted directly. |
| L1-502 | **Paediatric Early Warning System**<br><br>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care. | N | A system was in use but from the notes reviewed at the time of the visit the process did not appear to be followed. See main report |
| L1-503 | **Resuscitation and Stabilisation**<br><br>Hospital-wide protocols for resuscitation and stabilisation should be in use, including:<br>a. Alerting the paediatric resuscitation team<br>b. Arrangements for accessing support for difficult airway management<br>c. Stabilisation and ongoing care<br>d. Care of parents during the resuscitation of a child | Y | |

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| L1-504 | **Paediatric Advice**<br><br>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. | N/A | |
| L1-505 | **Clinical Guidelines**<br><br>The following clinical guidelines should be in use:<br>**All:**<br>a. Treatment of all major conditions, including:<br>i. i. acute respiratory failure (including bronchiolitis and asthma)<br>ii. ii. sepsis (including septic shock and meningococcal infection)<br>iii. iii. management of diabetic ketoacidosis<br>iv. iv. seizures and status epilepticus<br>v. v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable)<br>vi. vi. burns and scalds<br>vii. vii. cardiac arrhythmia<br>viii.viii. upper airway obstruction<br>b. Management of acutely distressed children, including use of restraint<br>c. Drug administration and medicines management<br>d. Pain management<br>e. Procedural sedation and analgesia<br>f. Infection control and antibiotic prescribing<br>g. Tissue viability, including extravasation<br>h. Nasal high flow therapy (if used)<br>i. Management of children undergoing surgery (if applicable)<br>j. Rehabilitation after critical illness (if applicable) | N | Different versions of guidance were accessible, which caused confusion for staff. Some guidance was on the intranet and some of the Paediatric in Partnership (PIP) guidelines from 2017 on the ward. A review of guidance was taking place and the Trust was in the process of implementing PIP guidelines which were being checked for use locally. |
| L1-506 | **PCC Transfer Guidelines**<br><br>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:<br>a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information<br>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<br>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 | N | Guidance was due for review in December 2017. |

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| L1-507 | **In-hospital Transfer Guidelines**<br><br>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 | |
| L1-508 | **Inter-hospital Transfer Guidelines**<br><br>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:<br>a. Types of patients transferred<br>b. Composition and expected competences of the escort team<br>c. Drugs and equipment required<br>d. Restraint of children, equipment and staff during transfer<br>e. Monitoring during transfer | Y | Though see main report. |
| L1-509 | **Time-Critical Transfer Guidelines**<br><br>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:<br>a. Securing advice from the Specialist Paediatric Transport Service (QS L1-506)<br>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<br>c. Indemnity for escort team<br>d. Availability of drugs and equipment, checked in accordance with local policy (QS L1-402)<br>e. Arrangements for emergency transport with a local ambulance service and the air ambulance<br>f. Arrangements for ensuring restraint of children, equipment and staff during transfer | N | The policy for time critical transfers was included as part of the Management of the Critical Ill child, but did not cover all the requirements of the QS. |

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| L1-601 | **Operational Policy**<br><br>All:<br>The service should have an operational policy covering at least:<br>a. Individualised management plans are accessible for children who have priority access to the service (where applicable)<br>b. Informing the child's GP of their attendance / admission<br>c. Level of staff authorised to discharge children<br>d. Arrangements for consultant presence during 'times of peak activity' (7/7)<br>e. Servicing and maintaining equipment, including 24 hour call out where appropriate<br>f. Arrangements for admission within four hours of the decision to admit<br>g. Types of patient admitted<br>h. Review by a senior clinician within four hours of admission<br>i. Discussion with a consultant within four hours of admission<br>j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours<br>k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff<br>l. Discussion with a senior clinician prior to discharge | Y | |
| L1-702 | **Data Collection**<br><br>The service should collect:<br>a. Paediatric Intensive Care Audit Network (PICANet) data<br>b. Paediatric Critical Care Minimum Data Set for submission to Secondary Uses Service (SUS)<br>c. 'Quality Dashboard' data as recommended by the PCC Clinical Reference Group (CRG) | N | Data collection was in place for 'a;' and 'b' but not for 'c' |
| L1-703 | **Audit and Quality Improvement**<br><br>The service should have a rolling programme of audit, including at least:<br>a. Audit of implementation of evidence based guidelines (QS L1-500s)<br>b. Participation in agreed national and network-wide audits<br>c. Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations | Y | 'c' was not applicable |

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| L1-704 | **Key Performance Indicators**<br><br>Key performance indicators should be reviewed regularly with Hospital (or equivalent) management and with commissioners. | Y | |
| L1-798 | **Review and Learning**<br><br>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 | |

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