WM QRS West Midlands Quality Review Service

NHS Midlands and East Specialised Commissioning Group

Quality Standards

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

Version 4.2

December 2013

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Review by: December 2019 at the latest

Version Number	**Date**	**Change from Previous Version**
V4	01.03.13	N/A
V4.1	1.10.13	QS PM-107 deleted. QS PM-501 reworded
V4.2	10.12.13	QS PM-501 reworded

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FOREWORD

This is the fourth version of “Standards for the Care of Critically Ill and Injured Children” to be published in the West Midlands and continues a project that was first initiated in the year 2000. It is a tribute to the many who have contributed to the whole paediatric peer review process over the years that use of the Standards continues to produce improvements in clinical practice and service organisation.

In this version we have taken account of the recently published standards for care of children suffering traumatic injury, including those for the organisation of Trauma Centres and Trauma Units.

Current work relates to” High Dependency Care” – an area of practice which has been notoriously difficult to consistently define and as a corollary of that, it has been hard to write detailed clinical standards for use in service organisation and clinical audit. We hope soon, in collaboration with a Royal College of Paediatrics and Child Health working group, to be more specific and comprehensive in this section of the Standards.

We hope that these Standards will be used for peer review of services for critically ill and critically injured children across the West Midlands during 2013/14.

I am very pleased to commend this Version to you and must thank again all those of my colleagues on the Steering Group who have given up their time unselfishly to supporting their development and revision.

Charles S Ralston

Chair of the Steering Group
March 2013

INTRODUCTION

These Quality Standards aim to improve the quality of care of critically ill and critically injured children. They help to answer to the question: "For each service, how will I know that national guidance and evidence of best practice have been implemented?" and are suitable for use in service-specifications, self-assessment and peer review visits. The Quality Standards describe what services should be aiming to provide and all services should be working towards meeting all applicable Quality Standards.

The Standards have been developed by a Steering Group chaired by Dr Charles Ralston (Appendix 1). The Standards are sponsored by the West Midlands Specialised Commissioning Group, which commissions specialised services on behalf of the West Midlands Primary Care Trusts Clusters, and is now part of the Midlands and East Specialised Commissioning Group.

Appendix 2 contains a glossary of terms and abbreviations used in the Standards and Appendix 3 lists relevant national guidance.

We hope that through the quality standards and, at some future date, a peer review programme:

1 Service quality will improve.

2 Children, young people and families will know more about the services they can expect.

3 Commissioners will be supported in assessing and meeting the needs of their population, improving health and reducing health inequalities, and will have better service specifications.

4 Service providers and commissioners will have external assurance of the quality of local services.

5 Reviewers will learn from taking part in review visits.

6 Good practice will be shared.

7 Service providers and commissioners will have better information to give to the Care Quality Commission and Monitor.

SCOPE OF THE STANDARDS

These Standards cover the pathway for the care of critically ill and critically injured children with the following exceptions:

- Care provided by general practitioners.
- Standards for Major Trauma Centres for Children: Separate standards and a review process cover this aspect of care.
- Standards for Retrieval and Transfer of the Most Critically Ill Children and for Paediatric Intensive Care: These Standards are given in *Standards for the Care of Critically Ill Children*, Paediatric Intensive Care Society, V 4, June 2010.

These Standards link with other WMQRS Quality Standards, in particular those for:

- Urgent Care Services
- Critical Care

The latest versions of these Quality Standards are available on the WMQRS website: www.wmqrs.nhs.uk

STRUCTURE OF THE STANDARDS

Trust-wide Standards

These standards apply to all Trusts that provide care for critically ill children, including those providing retrieval services or intensive care. They also apply to Trusts with Emergency Departments which are signposted for all ages but which are by-passed by ambulances carrying children. In self-assessment or peer review, these standards should be reviewed only once but reviewers should ensure that they are met in all services for critically ill children provided by the Trust.

Emergency Departments, Children's Assessment Services and In-patient Children's Services

These standards are additional to the Trust-wide standards and apply to each Emergency Department (including those aiming to treat adults only), children's assessment services and services providing day case or in-patient care for children. They also apply to wards within children's hospitals. They do not apply to general (adult) intensive care units, retrieval services or Paediatric Intensive Care Units. When used for self-assessment or peer review, the standards in this section should be reviewed separately for each area that is separately managed or staffed. These standards fall into three sections:

Core standards for each area

These standards apply to each Emergency Department, children's assessment service and unit providing day case or in-patient care for children. These services may need to provide short-term critical care until the Retrieval Service arrives. They may also have to transfer a child to an intensive care unit when, because of the urgency of the situation, waiting for the Retrieval Service to arrive would introduce potentially dangerous delay.

Emergency Departments Caring for Children

These standards apply to Emergency Departments, children's assessment services and general children's wards that accept emergency admissions.

In-Patient and High Dependency Care of Children

All hospitals providing in-patient care of children should be prepared to provide short-term critical care until the child is transferred to a high dependency or intensive care service. Some hospitals will provide a high dependency care service.

Anaesthesia and General Intensive Care for Children

These standards are additional to the Trust-wide standards and apply to all services providing anaesthesia for children and to general (adult) Intensive Care Units into which children may be transferred for short periods until their condition improves or the Retrieval Service arrives. Children's hospitals are expected to meet the paediatric anaesthesia standards but not the standards for general Intensive Care Units.

Retrieval and Transfer of the Most Critically Ill Children

(See Paediatric Intensive Care Society, Standards for the Care of Critically Ill Children, V 4, June 2010)

These standards are additional to the Trust-wide standards and apply to services that undertake retrieval and transfer of the most critically ill children. Retrieval services may be managed separately from PICU or may be integrated with PICU.

Paediatric Intensive Care

(See Paediatric Intensive Care Society, Standards for the Care of Critically Ill Children, V4, June 2010)

These standards are additional to the Trust-wide standards and apply to units providing paediatric intensive care. These units may also provide a Retrieval Service.

The applicable standards therefore depend on the local configuration of services. Figure 1 illustrates the standards applicable to different settings.

Figure 1 Applicable standards

Applicable standards	Emergency Department	Children's Assessment Unit	In-patient Children's Ward	In-patient Children's Ward (elective admissions only)	Anaesthesia service & general ICU	Retrieval Service	PICU
Trust-wide core standards*	√	√	√	√	√	√	√
Emergency Departments, Children's Assessment Units, In-patient and High Dependency Services for Children							
Core standards for each area	√	√	√	√			
Emergency Departments Caring for Children	√						
In-Patient and High Dependency Care Services**			√	√			
Anaesthesia & General Intensive Care for Children					√		
Retrieval and transfer of the most critically ill children						√	
Paediatric Intensive Care							√

* Trust-wide core standards are reviewed once for each Trust.

** Some Standards are applicable only to hospitals providing high dependency care services

Each section of the standards starts with a set of Objectives. These indicate the intentions behind the detail of the Standards. They also provide guidance in the event of any doubt about the interpretation of the Standards.

Each Standard has the following structure:

Reference Number (Ref)	This column contains the reference number for each Standard which is unique to these standards and is used for all cross-referencing. Each reference number is composed of two letters (the first identifying the care pathway and the second the service to which a standard applies) and three digits (the first identifying the relevant section and the last two being unique to that Quality Standard). The reference column also includes a guide to how the Standard will be reviewed: BI – Background information for the review team Visit – Visiting facilities MP&S – Meeting patients, carers and staff CNR – Case note review or clinical observation Doc – Documentation should be available The shaded area indicates the approach that will be used to reviewing the Quality Standard. Appendix 4 summarises the evidence needed for review visits.
Quality Standard (QS) *Notes*	This describes the quality that services are expected to provide. *The notes give more detail about either the interpretation or the applicability of the Standard.*

Pathway and Service Letters

All of the Quality Standards

PC-	Care of Critically Ill Children Pathway	Acute Trust-wide
PM-	Care of Critically Ill Children Pathway	Core Standards for Each Area: Emergency Departments, Children's Assessment Services, In-patient and High Dependency Care Services for Children
PE-	Care of Critically Ill Children Pathway	Emergency Departments Caring for Children
PQ-	Care of Critically Ill Children Pathway	In-patient and High Dependency Care Services for Children
PG-	Care of Critically Ill Children Pathway	Anaesthesia and General Intensive Care for Children

Topic Sections

Each Quality Standard reference number has three numbers after the 'dash'. The first number identifies the relevant section and the last two are unique to the Quality Standard.

-100	Information and Support for Children and Their Families
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

COMMENTS ON THE QUALITY STANDARDS

The Quality Standards will be revised as new national guidance becomes available and as a result of experience of its use in peer review. Comments on the Quality Standards are welcomed and will be taken into account when it is updated. Comments should be sent to swb-tr.SWBH-GM-WMQRS@nhs.net .

More information about WMQRS and its Quality Standards and reviews is available at www.wmqrs.nhs.uk or 0121 507 2891.

TRUST-WIDE STANDARDS

OBJECTIVES

- All NHS Trusts should be clear of their role in the care of critically ill and critically injured children and of the other units that will normally be expected to provide other elements of this care.
- All NHS Trusts should comply with published guidance on health services for children, in particular, the National Service Framework for Children — Standard for Hospital Services.
- Walk-in Centres and hospitals with Minor Injury Units should receive only children with minor clinical conditions and have in place a protocol for use in the event of a critically ill child, or potentially critically ill child, presenting.
- All NHS Trusts should ensure that staff caring for critically ill and critically injured children have the competences needed for the roles they will be undertaking and appropriate arrangements for maintaining these competences.

Responsibility for these Quality Standards (QS) lies with the Lead Director for Children's Services (QS PC-201).

Ref.	Quality Standard	
STAFFING		
PC-201 BI Visit MP&S CNR Doc	**Board-level lead for children** A Board-level lead for children's services should be identified.	
	Cross Reference CQC: 6A, 13A	*Cross Reference NHSLA: 1.9*
PC-202 BI Visit MP&S CNR Doc	**Lead consultants and lead nurses** The Board level lead for children's services should ensure that the following leads for the care of children have been identified: a. Nominated lead consultants and nurses for each of the areas where children may be critically ill (QS PM-201) b. Nominated lead consultant for emergency and elective surgery in children c. Nominated lead consultant for trauma in children d. Nominated lead anaesthetist (QS PG-201) and lead ICU consultant (QS PG-202) for children *Notes: A lead surgeon is not applicable to Trusts which do not provide surgery for children. A lead consultant for trauma is not applicable to Trusts which do not receive children with trauma. A lead ICU consultant for children is not applicable in Trusts where the general intensive care unit is not one of the possible areas for maintenance of intensive care (QS PM-506).*	
	Cross Reference CQC: 4B , 6A, 13A, 14D, 14J	*Cross Reference NHSLA: 1.1, 1.9*

Ref.	Quality Standard	
GUIDELINES AND PROTOCOLS		
PC-501 BI Visit MP&S CNR Doc	**Minor injuries units** If the Trust's services (QS PC-601) include a Minor Injuries Unit, Walk-in Centre or Urgent Care Centre, this Unit should have a protocol in use in the event of a critically ill child, or potentially critically ill child, presenting. This protocol should include transfer to an appropriate paediatric unit. *Notes:* *1 This QS applies only to Minor Injuries Units, Walk-in Centres and Urgent Care Centres.* *2 If these are the only services for critically ill and critically injured children provided by the Trust then no other QSs are applicable.*	
	Cross Reference CQC : 1D,4B, 6A, 6C, 16E	*Cross Reference NHSLA: 4.8, 4.9*
PC-502 BI Visit MP&S CNR Doc	**Hospitals with emergency services for adults only – avoiding child attendances** Hospitals without on-site assessment or in-patient services for children should: a. Indicate clearly to the public the nature of the service provided for children b. Have agreed a protocol with the local ambulance service that children are not brought to the service by ambulance *Note: This QS does not apply to hospitals providing an Emergency Department for children, children's assessment services or in-patient children's services.*	
	Cross Reference CQC: 1H, 4B	*Cross Reference NHSLA: 5.2*
PC-503 BI Visit MP&S CNR Doc	**Hospitals with emergency services for adults only – paediatric advice** Hospitals without on-site assessment or in-patient services for children should have guidelines for accessing paediatric medical advice agreed with a local paediatric medical unit and regularly reviewed. *Note: This QS does not apply to hospitals providing an Emergency Department for children, children's assessment services or in-patient children's services.*	
	Cross Reference CQC : 1H, 4B	*Cross Reference NHSLA: 5.2*
PC-504 BI Visit MP&S CNR Doc	**Surgery on children** The Trust should have agreed the exclusion criteria for elective and emergency surgery on children (QS PG-503).	
	Cross Reference CQC: 4A, 4B	*Cross Reference NHSLA: 2.8*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
PC-601 BI Visit MP&S CNR Doc	**Services provided** The Trust should be clear whether it provides the following services and the hospital site or sites on which each service is available: a. Minor Injury Unit, Walk-in Centre or Urgent Care Centre b. Emergency Department for: ○ Adults ○ Children c. Trauma service for children and, if so, its designation d. Children's assessment service e. In-patient children's service f. High Dependency Care service for children g. Elective in-patient surgery for children h. Day case surgery for children i. Emergency surgery for children j. Acute pain service for children k. Paediatric Intensive Care retrieval and transfer service l. Paediatric Intensive Care service *Note: An acute pain service is expected in all hospitals providing care for children with trauma.*
	Cross Reference CQC: 1H, 4B, 10A
PC-602 BI Visit MP&S CNR Doc	**Children's assessment service location** If the Trust provides a children's assessment service, this should be sited alongside either an Emergency Department or an in-patient children's service. *Note: This QS is not applicable to Trusts which do not provide a children's assessment service.*
	Cross Reference CQC: 1H, 4B, 10A
PC-603 BI Visit MP&S CNR Doc	**Hospitals accepting children with trauma** Hospitals accepting children with trauma should also provide, on the same hospital site: a. High Dependency Care service for children b. Paediatric Intensive Care service or a general intensive care unit which admits children needing: ○ A short period of post-anaesthetic care ○ Maintenance prior to transfer to PICU (QS PM-506) *Note: This QS applies only to hospitals which accept children with trauma.*
	Cross Reference CQC: 1H, 4B, 4H

Ref.	Quality Standard	
PC-604 BI Visit MP&S CNR Doc	**Trust-wide group** Trusts providing hospital services for children should have a single group responsible for the coordination and development of care of critically ill and critically injured children. The membership of this group should include all nominated leads (QS PC-202) and the Resuscitation Officer with lead responsibility for children. The accountability of the group should include the Trust Director with responsibility for children's services (QS PC-201). The relationship of the group to the Trust's mechanisms for safeguarding children (QS PM-297) and clinical governance issues relating to children should be clear. *Note: This group may have other functions so long as the QS is met in relation to terms of reference, membership and accountability.*	
	Cross Reference CQC: 6A, 6C	*Cross Reference NHSLA: 1.4, 1.9, 2.6*
GOVERNANCE		
PC-703 BI Visit MP&S CNR Doc	**Approving guidelines and policies** The mechanism for approval of policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should have been agreed by the Trust-wide group (QS PC-604) or a sub-group thereof. *Note: The mechanism for approval may be through the group itself or through other structures within the Trust.*	
	Cross Reference CQC: 4B, 16A	*Cross Reference NHSLA: 1.2*
PC-704 BI Visit MP&S CNR Doc	**Child death** The death of a child while in hospital should undergo formal review. This review should be multi-professional and all reasonable steps should be taken to involve specialties who contributed to the child's care. Primary and community services should be involved where appropriate. All deaths of children in hospital should be reported to the local Child Death Overview Panel.	
	Cross Reference CQC: 4B, 4M, 9J	*Cross Reference NHSLA: 2.2, 2.5, 2.6, 2.9*

Emergency Departments, Children's Assessment Services, In-patient and High Dependency Care Services for Children

Objectives

- All services should comply with relevant national guidance on caring for children.
- Critically ill and critically injured children should be cared for in an appropriate environment and, wherever possible, participate in decisions about their care.
- Families should be able to participate fully in decisions about the care of their child and in giving this care.
- Appropriate support services should be available to children and their families during the child's critical illness and, if necessary, through bereavement.
- Care should be provided by appropriately trained staff in appropriately equipped facilities.
- With the exception of elective day surgery, availability of services should not vary over a 24 hour period.
- All services should have a multi-disciplinary approach to care where the expertise of all members of the multi-disciplinary team is valued and utilised.
- All services should have robust arrangements for assessment, resuscitation, stabilisation and maintenance of critically ill and critically injured children until their condition improves or the Retrieval Service arrives.
- All in-patient children's services should have appropriate staffing and facilities to initiate and provide short-term critical care until the child is transferred to a high dependency or intensive care service, or their condition improves.
- All children needing critical care, including intensive care and high dependency care, should be transferred to an appropriate Paediatric Intensive Care service or High Dependency Care Unit unless their condition is expected to improve within the next 24 hours.
- All services should have robust arrangements for transfer to a Paediatric Intensive Care service by the Retrieval Service covering the local population.
- All services should be prepared to transfer a child to a Paediatric Intensive Care service when, because of the urgency of the situation, waiting for the Retrieval Service to arrive would introduce potentially dangerous delay. Such transfers should be carried out by appropriately trained and equipped staff.
- All services should have appropriate governance arrangements, including data collection and audit.

CORE STANDARDS FOR EACH AREA

These Quality Standards apply to each area of the hospital where a) critically ill and critically injured children may arrive and / or b) where day case or in-patient care is given.

Support for children and their families is needed throughout a critical illness. Appendix 5 gives further advice on facilities and support for families of critically ill children and on provision for play as part of the child's continued development.

Responsibility for these Standards lies with the nominated lead consultant and nominated lead nurse (QS PM-201) for each area. Ensuring the appointment of a nominated lead consultant and nominated lead nurse for each area is the responsibility of the Lead Director for Children's Services (QS PC-201).

Ref.	Quality Standard	
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES		
PM-101 BI Visit MP&S CNR Doc	**General support for families** The following support services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services Information for parents about these services should also be available. *Notes:* *1 'Availability' of support services is not defined but should be appropriate to the case mix and needs of the patients.* *2 As QS PM-103*	
	Cross Reference CQC : 6A, 13A	
PM-102 BI Visit MP&S CNR Doc	**Child-friendly environment** There should be a child-friendly environment, including toys and books / magazines for children of all ages. There should be visual and, ideally, sound separation from adult patients. *Note: This QS does not apply to areas used only for resuscitation of children.*	
	Cross Reference CQC: 10A, 10I	*Cross Reference NHSLA: 4.1*
PM-103 BI Visit MP&S CNR Doc	**Parental access** There should be parental access to the child at all times except when this is not in the interest of the child or the privacy and confidentiality of other children and their families. *Note: Information should be available in formats and languages appropriate to the needs of the patients and their families.*	
	Cross Reference CQC: 10A	*Cross Reference NHSLA: 2.8*
PM-104 BI Visit MP&S CNR Doc	**Information for children** Children should be offered appropriate information to enable them to share in decisions about their care. *Note: As QS PM-103.*	
	Cross Reference CQC: 1E, 1F	*Cross Reference NHSLA: 5.2*

Ref.	Quality Standard	
PM-105 BI Visit MP&S CNR Doc	**Information for parents** Parents should have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child. *Note: As QS PM-103.*	
	Cross Reference CQC: 1C, 1F	*Cross Reference NHSLA: 5.2*
PM-106 BI Visit MP&S CNR Doc	**Keeping parents informed** Parents should be informed of the child's condition, care plan and retrieval (if necessary) and this information should be updated regularly. *Note: As QS PM-103.*	
	Cross Reference CQC: 1H, 4A	*Cross Reference NHSLA: 5.2*
PM-108 BI Visit MP&S CNR Doc	**Financial support** A policy on financial support for families of critically ill children should be developed and communicated to parents. *Notes:* *1 This QS is not applicable to emergency services for adults only.* *2 As QS PM-103.*	
	Cross Reference CQC: 1H	
PM-199 BI Visit MP&S CNR Doc	**Involving children and families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups and/or other arrangements. They may be part of Trust-wide arrangements so long as issues relating to children's services can be identified.*	
	Cross Reference CQC: 1J, 4E, 4I	*Cross Reference NHSLA: 2.6*
STAFFING		
PM-201 BI Visit MP&S CNR Doc	**Lead consultant and lead nurse** A nominated consultant and nominated senior children's trained nurse should be responsible for: a. Protocols covering the assessment and management of the critically ill child b. Ensuring training of relevant staff The lead consultant and lead nurse should undertake regular clinical work within the area for which they are responsible.	
	Cross Reference CQC: 6C, 13A, 14A	*Cross Reference NHSLA: 3.5*
PM-202 BI Visit MP&S CNR Doc	**Consultant paediatrician 24 hour cover** 24 hour cover by a consultant paediatrician who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available. *Notes:* *1 This QS is not applicable to hospital sites providing emergency services for adults and no other services for critically ill children.* *2 On hospital sites providing day surgery only, this QS applies to the time when children may be present.*	

Ref.	Quality Standard	
	Cross Reference CQC: 13A	
PM-203 BI Visit MP&S CNR Doc	**Consultant anaesthetist 24 hour cover** 24 hour cover by a consultant anaesthetist who is able to attend within 30 minutes and does not have responsibilities to other hospital sites should be available.	
	Cross Reference CQC: 13A	*Cross Reference NHSLA: 1.9*
PM-204 BI Visit MP&S CNR Doc	**24 hour on site clinician competent in resuscitation and advanced airway management** 24 hour cover by a clinician with competences in resuscitation, stabilisation and intubation of children should be immediately available on each hospital site. *Notes:* *1 On hospital sites providing day surgery only, this QS applies to the time when children may be present.* *2 The QS may be met by different staff who have competences in intubation of children of different ages so long as there are robust arrangements for intubation of children of all ages at all times.*	
	Cross Reference CQC: 13A, 14G	*Cross Reference NHSLA: 1.9, 3.5*
PM-205 BI Visit MP&S CNR Doc	**Medical staff resuscitation training** All relevant medical staff and clinical staff (QS PM-201) have appropriate, up to date paediatric resuscitation training. *Note: The level of training and updating appropriate to different staff is shown in Appendix 6.*	
	Cross Reference CQC: 6C, 13A, 14A, 14G	*Cross Reference NHSLA: 3.5. 4.8*
PM-206 BI Visit MP&S CNR Doc	**Clinician with advanced resuscitation training on duty** A clinician with up to date advanced paediatric resuscitation training should be on duty at all times. *Notes:* *1 In areas providing day surgery only, this QS applies to the time during which children may be present.* *2 The level of training and updating appropriate to different staff is shown in Appendix 6.*	
	Cross Reference CQC: 6C, 13A, 14A, 14G	*Cross Reference NHSLA: 3.5, 4.8*
PM-207 BI Visit MP&S CNR Doc	**Clinician with level 1 competences on duty** There should be 24 hour resident cover by a clinician with competences and experience in: a. Assessment of the ill child and recognition of serious illness and injury b. Initiation of appropriate immediate treatment c. Prescribing and administering resuscitation and other appropriate drugs d. Provision of appropriate pain management e. Effective communication with children and their families The level of competence expected is equivalent to paediatric medicine (RCPCH) level 1 competences in these areas. *Notes:* *1 The clinician with these competences should be immediately available but may or may not be based within the area being reviewed.* *2 In areas providing day surgery only, this QS applies to the time during which children may be present.* *3 RCPCH competence frameworks are available at:* ***www.rcpch.ac.uk/Training/Competency-Frameworks***	

Ref.	Quality Standard	
	Cross Reference CQC:13A, 14A, 14G	*Cross Reference NHSLA: 3.5, 4.8*
PM-208 BI Visit MP&S CNR Doc	**Nursing and HCA staff competences** Nursing and health care assistant staffing and competency levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. A competence framework and training plan should ensure that all nursing and health care assistant staff have, or are working towards, competences appropriate for their role in the service including in: a. Paediatric resuscitation b. High dependency care c. Care and rehabilitation of children with trauma *Notes:* *1 As QS PM-205.* *2 Appropriate staffing levels are not strictly defined. RCN "Defining Staffing Levels for Children's and Young People's services" gives advice on sufficiency of staffing.* *3 Documentation needed to demonstrate compliance with this QS includes staffing details (establishment and 'in post'), escalation policy, competence framework and training plan.* *4 Other courses are also available. Nurses providing specialist care for specific conditions (for example, burns, renal, cardiac liver disease) should have completed a high dependency module or additional high dependency training as part of their specialist training.*	
	Cross Reference CQC: 6A, 13A, 14A	*Cross Reference NHSLA: 1.9, 3.1, 3.2, 3.5, 4.8*
PM-209 BI Visit MP&S CNR Doc	**Minimum nurse staffing** Emergency Departments and day surgery services for children should have at least one registered children's nurse on duty at all times in each area. Children's assessment services and in-patient services for children should have at least two registered children's nurses on duty at all times in each area. *Notes:* *1 Services should be planning to achieve this QS. The RCN has set a target date of 2015 for full implementation.* *2 Small services which are co-located may share staff.*	
	Cross Reference CQC: 6A, 13A, 14A	*Cross Reference NHSLA: 1.9, 3.1, 3.2, 3.5, 4.8*
PM-210 BI Visit MP&S CNR Doc	**Nurse with paediatric resuscitation training on duty** At least one nurse with up to date paediatric resuscitation training should be on duty at all times. *Notes: As QS PM-205.*	
	Cross Reference CQC: 6A, 13A, 14A	*Cross Reference NHSLA: 1.9, 3.1, 3.2, 3.5, 4.8*
PM-211 BI Visit MP&S CNR Doc	**Support for play** Appropriately qualified play specialists should be available 7 days a week. *Notes:* *1 At least one play specialist should have the Hospital Play Specialist or equivalent qualification.* *2 This QS is not applicable to emergency services for adults only or Emergency Departments seeing less than 16,000 children per year. Emergency Departments seeing less than 16,000 children per year should however have regular advice and support from play specialists.*	
	Cross Reference CQC: 6A, 13A, 14A	*Cross Reference NHSLA: 3.1, 3.2*

Ref.	Quality Standard	
PM-296 BI Visit MP&S CNR Doc	**Policy on staff acting outside their area of competence** A Trust policy on staff acting outside their area of competence because this is in the best interest of the child should be in use covering: a. Exceptional circumstances when this may occur b. Staff responsibilities c. Reporting of event as an untoward clinical incident d. Support for staff *Note: This policy, for example, covering the need to undertake the transfer of a child when waiting for the Retrieval Service would introduce potentially dangerous delay, should be communicated to staff throughout children's services.*	
	Cross Reference CQC: 4B	*Cross Reference NHSLA: 2.2, 2.6*
PM-297 BI Visit MP&S CNR Doc	**Safeguarding training** All staff involved with the care of children should: a. Have training in safeguarding children appropriate to their role b. Be aware who to contact if they have concerns about safeguarding issues and c. Work in accordance with latest national guidance on safeguarding children *Note: This QS is included because compliance with national safeguarding requirements is essential. Detailed consideration of safeguarding arrangements is covered by other review processes.*	
	Cross Reference CQC: 6E, 7A-L, 14A	*Cross Reference NHSLA: 3.5*
SUPPORT SERVICES		
PM-301 BI Visit MP&S CNR Doc	**Support services 24 hour cover** 24-hour access to pharmacy, biochemistry, pathology, imaging and physiotherapy services able to support the care of children, and weekday access to dietetic services, should be available. If staff with competences in reporting imaging of children are not available 24/7 then the Trust should have arrangements for review of imaging by a paediatric radiologist. *Notes:* *1 This QS includes appropriate reporting arrangements. Services may be provided on site or through appropriate on call / network arrangements.* *2 Services receiving acutely ill and critically injured children should have CT scan and reporting available within one hour (QS PE-513).* *3 For services providing day surgery only, this QS applies to the time when children may be present.*	
	Cross Reference CQC: 4H, 13A, 14A, 14G	*Cross Reference NHSLA: 3.5*
FACILITIES AND EQUIPMENT		
PM-401 BI Visit MP&S CNR Doc	**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. *Note: Appendix 7 lists the drugs and equipment needed for resuscitation and stabilisation of critically ill children.*	
	Cross Reference CQC: 9H	*Cross Reference NHSLA: 4.8, 5.10*

Ref.	Quality Standard	
GUIDELINES, POLICIES AND PROCEDURES		
PM-501 BI Visit MP&S CNR Doc	**Initial Assessment** A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times exceed 30 minutes. *Notes:* *1 This QS is not applicable to services which take only elective admissions.*	
	Cross Reference CQC: 6A, 6C	*Cross Reference NHSLA: 4.8*
PM-502 BI Visit MP&S CNR Doc	**Paediatric advice** Protocols for accessing advice from the local paediatric service and local paediatric intensive care service should be in use in units where children are not under the care of a paediatrician. *Note : This QS applies to Emergency Departments, elective surgery wards and any other units where children are not under the care of a paediatrician. This QS is not applicable to services where care is managed by paediatric medical and nursing staff.*	
	Cross Reference CQC: 6A, 6C	*Cross Reference NHSLA: 4.8*
PM-503 BI Visit MP&S CNR Doc	**Clinical guidelines** Guidelines should be in use covering: a. Admission b. Treatment of all major conditions, including meningococcal infection, asthma, status epilepticus, diabetic ketoacidosis, upper airway obstruction and inhaled foreign body. c. Treatment of the consequences of trauma d. Procedural sedation and analgesia e. Discharge *Notes:* *1 Guidelines should be clear on the roles and responsibilities of all members of the multi-disciplinary team, including anaesthetic services (see QS PM-202 and PG-501)* *2 Guidelines should include actions to prevent / prepare for deterioration and may link with 'early warning' guidelines (QS PM-504).* *3 Guidelines on the treatment of trauma should be based on regional trauma guidelines.*	
	Cross Reference CQC: 4B	*Cross Reference NHSLA: 2.8*
PM-504 BI Visit MP&S CNR Doc	**Early warning protocol** A protocol designed to provide early warning of deterioration of children should be in use. The protocol should cover observation, monitoring and escalation of care. *Note: PEWS is one example of an appropriate early warning protocol.*	
	Cross Reference CQC: 1D, 4B, 16E	*Cross Reference NHSLA: 2.8, 4.8*

Ref.	Quality Standard	
PM-505 BI Visit MP&S CNR Doc	**Resuscitation and stabilisation protocol** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Indications and arrangements for accessing ENT services when needed for airway emergencies c. In Emergency Departments with no on-site children's assessment or in-patient children's service, arrangements for ensuring paediatric medical and appropriate anaesthetic input to the care of the child *Note: As QS PM-503 note 1.*	
	Cross Reference CQC: 1D, 4B, 6A, 6C, 16E	*Cross Reference NHSLA: 2.8, 4.8*
PM-506 BI Visit MP&S CNR Doc	**PICU transfer protocol** A protocol on transfer to a PICU should be in use, which should include: a. Accessing advice from a Retrieval Service or PIC consultant and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant with a PIC consultant c. Local guidelines on the maintenance of intensive care for a critically ill child until the child's condition improves or the retrieval team arrives which should stipulate the location/s in which children may be maintained d. Arrangements for the transfer of children requiring specialised intensive care not available in the lead PIC centre, including burns care and ECMO *Notes:* *1 Although the Retrieval Service / PICU will give advice, the management of the child remains the responsibility of the referring team until the child is transferred to the Retrieval Service / PICU team. It is also expected that the local paediatrician or anaesthetist will remain involved with the care of the child and support the work of the Retrieval Service while on-site.* *2 'KIDS' Referrals Chart can be downloaded from www.kids.bch.nhs.uk* *3 As QS PM-503 notes 1 and 2.* *4 Section 'd' of this QS is not applicable to services providing elective surgery only.*	
	Cross Reference CQC: 1D, 4B, 6A, 6C, 16E	*Cross Reference NHSLA: 4.8, 4.9*
PM-507 BI Visit MP&S CNR Doc	**In-hospital transfer protocol** A protocol on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The protocol should specify the escort arrangements and equipment required. *Note: This protocol may be combined with QS PM-506.*	
	Cross Reference CQC: 1D, 4B, 6A, 6C, 16E	*Cross Reference NHSLA: 4.8, 4.9*

Ref.	Quality Standard	
PM-508 BI Visit MP&S CNR Doc	**High dependency care transfer protocol** Hospitals which undertake transfers of children needing high dependency care should have a protocol agreed by the Retrieval Service for the local population which covers: a. Types of patients transferred b. Composition and expected competences of the escort team c. Drugs and equipment required d. Restraint of children, equipment and staff during transfer e. Monitoring during transfer The protocol should cover primary transfers of children to a High Dependency Care Unit and 'back-transfers' from PICU. *Notes:* *1 This QS is applicable only to hospitals which regularly undertake transfers of children needing high dependency care.* *2 Transfers of children needing high dependency care should not rely on the West Midlands Paediatric Retrieval Service 'KIDS'.* *3 This protocol may be combined with QS PM-506.*	
	Cross Reference CQC: 1D, 4B, 6A, 6C, 16E	*Cross Reference NHSLA: 4.8, 4.9*
PM-509 BI Visit MP&S CNR Doc	**Transfer contingency protocol** A protocol should be in place for situations where retrieval is clinically inappropriate or time-critical, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies, where retrieval may introduce unsafe delay. The protocol should include: a. Advice from the Retrieval Service or lead PIC centre (QS PM-506) b. Contact details of relevant specialists where additional advice may be required, for example, neurosurgeons c. Escort team of one nurse and one doctor with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the medical escort who would normally be senior clinicians with experience and / or training in a) care of the critically ill child or b) emergency transfer or c) airway management. d. Indemnity for escort team e. Availability of drugs and equipment, checked in accordance with local policy f. Arrangements for emergency transport with a local ambulance service and the air ambulance g. Arrangements for ensuring restraint of children, equipment and staff during transfer *Notes:* *1 The drugs and equipment listed in Appendix 7 are a guide to those that should be available for an emergency transfer.* *2 Information about ambulance services should include contact information, vehicle specification (road ambulance) and response times.* *3 All children, equipment and staff in the ambulance should be restrained during transfer in accordance with European CEN 1789/2000 Standard. Age-appropriate child restraint devices should either be available either within the department or there should be an arrangement with the ambulance service for such devices to be provided. Equipment used during transport should be capable of being secured to the stretcher and there should be no loose items in the rear cabin.*	
	Cross Reference CQC: 4B, 6C	*Cross Reference NHSLA: 4.8, 4.9*

Ref.	Quality Standard	
PM-510 BI Visit MP&S CNR Doc	**Organ donation policy** A Trust policy on organ donation should be in use which is specific about organ donation in children and includes transplant coordinator contact details. *Note: This QS does not apply to hospitals providing an emergency service for adults and no other services for children.*	
	Cross Reference CQC: 4B	*Cross Reference NHSLA: 5.2*
PM-511 BI Visit MP&S CNR Doc	**Bereavement policy** A Trust bereavement policy should be in use which specifically covers the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems. *Note: This QS does not apply to hospitals providing an emergency service for adults and no other services for children.*	
	Cross Reference CQC: 1A, 2A, 2B, 2D, 2E	*Cross Reference NHSLA: 5.2, 5.3*
GOVERNANCE		
PM-702 BI Visit MP&S CNR Doc	**Audit** The service should have a rolling programme of audit of compliance with clinical guidelines (QSs PM-503 to PM-509). *Note: The rolling programme should ensure that action plans are developed following audits and that implementation is monitored.*	
	Cross Reference CQC : 4B, 16A	*Cross Reference NHSLA: 2.1*
PM-703 BI Visit MP&S CNR Doc	**National audit programmes** The service should be submitting data to, and participating in, appropriate national and regional clinical audit programmes including, for services caring for children with trauma, TARN.	
	Cross Reference CQC: 4B, 16A	*Cross Reference NHSLA: 2.1*
PM-798 BI Visit MP&S CNR Doc	**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'. *Note: This QS is additional to the requirements of QSs for review with the Retrieval Service and PICU.*	
	Cross Reference CQC: 4B, 4D, 9J	*Cross Reference NHSLA: 2.1, 2.2, 2.6, 4.9*
PM-799 BI Visit MP&S CNR Doc	**Document control** All policies, procedures, guidelines and protocols relating to the care of critically ill and critically injured children should comply with Trust document control procedures.	
	Cross Reference CQC: 4B, 9J, 16A, 16C, 16E	*Cross Reference NHSLA: 1.2*

EMERGENCY DEPARTMENTS CARING FOR CHILDREN

These Standards apply to all Emergency Departments which provide care for children. They are additional to the standards found in the section headed 'Core Standards for Each Area' which should also be met. Responsibility for these Standards lies with the nominated lead consultant and nominated lead nurse (QS PM-201) for each area.

Ref.	Quality Standard
STAFFING	
PE-212 BI Visit MP&S CNR Doc	**Trauma team** Emergency Departments receiving children with trauma should have a Trauma Team immediately available at all times, including: a. Team Leader (see note 2) b. Emergency Department doctor (senior decision maker) c. Clinician trained to, or training at, the equivalent of paediatric medicine and neonatal medicine (RCPCH) level 2 competences or above (QS PQ-217) d. Clinician with competences in resuscitation, stabilisation and intubation of children (QS PM-203) e. General Surgeon f. Orthopaedic Surgeon *Notes:* *1 This QS applies only to Emergency Departments accepting children with Trauma.* *2 The Team Leader may be a member of the Team for the first 30 minutes. Consultants in Emergency Medicine, Paediatrics, General Surgery and Trauma and Orthopaedics should be available within 30 minutes.* *3 The Emergency Department senior decision-maker should be a doctor of ST4 or above.* *4 The clinician trained to, or training at, RCPCH level 2 competences may be an ST3 doctor.* *Cross Reference CQC: 13A, 14A, 14G, 14J* — *Cross Reference NHSLA: 4.8*
PE-213 BI Visit MP&S CNR Doc	**ED liaison paediatrician** There should be a nominated paediatric consultant responsible for liaison with the nominated Emergency Department consultant (QS PM-201). *Cross Reference CQC: 6C, 13A* — *Cross Reference NHSLA: 1.9*
PE-214 BI Visit MP&S CNR Doc	**ED sub-speciality trained consultant** Emergency departments seeing 16,000 or more child attendances per year should have an emergency department consultant with sub-specialty training in paediatric emergency medicine and a consultant paediatrician with sub-specialty training in paediatric emergency medicine. *Note: This QS is applicable only to departments seeing 16,000 or more children and young people per year.* *Cross Reference CQC: 13A, 14G* — *Cross Reference NHSLA: 1.9, 3.5*
PE-215 BI Visit MP&S CNR Doc	**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. *Note: This QS is not applicable to Emergency Departments seeing 16,000 or more children and young people per year.*

Ref.	Quality Standard	
	Cross Reference CQC: 13A, 14G	*Cross Reference NHSLA: 1.9, 3.5*
SUPPORT SERVICES		
PE-302 BI Visit MP&S CNR Doc	**Critical care support** Emergency Departments accepting children with trauma should have access, on the same hospital site, to: a. High Dependency Care service for children b. Paediatric Intensive Care service or a general intensive care unit which admits children needing: • A short period of post-anaesthetic care • Maintenance prior to transfer to PICU (QS PM-506) *Notes:* *1 This QS applies only to hospitals which accept children with trauma.* *2 This QS duplicates QS PC-603.*	
	Cross Reference CQC: 1H, 4B, 4H	
GUIDELINES AND PROTOCOLS		
PE-511 BI Visit MP&S CNR Doc	**Trauma protocol** A protocol on care of children with trauma should be in use covering: a. Dedicated phone in the Emergency Department b. Alerting and activating the Trauma Team (QS PE-212) c. Handover from the pre-hospital team to the Trauma Team lead using ATMIST d. Responsibilities of members of the Trauma Team, including responsibility for: i. Liaison with families ii. Calling all relevant consultants e. Involvement of neurosurgeons in all decisions to operate on children with traumatic brain injury f. Indications and arrangements for referral to the Major Trauma Centre for children, including referral of children needing assessment for: i. Neurosurgery ii. Vascular surgery iii. Cardiothoracic surgery iv. Spinal cord service v. Other specialist surgery g. Handover of children no longer needing the care of the Trauma Team h. Completing standardised documentation i. Responsibilities for recording receipt of imaging reports j. Major incidents *Notes:* *1 This QS applies only to Emergency Departments accepting children with trauma.* *2 The protocol may be combined with the adult trauma protocol.* *3 Trauma Units are expected to manage the care of children with injuries not requiring transfer to a Major Trauma Centre and those for whom direct transfer to a Major Trauma Centre could adversely affect outcomes.* *4 Standardised documentation should be based on network guidance.* *5 ATMIST refers to Age, Time, Mechanism of injury, Injuries, Signs, Treatment.*	
	Cross Reference CQC: 4B	*Cross Reference NHSLA: 2.8, 4.8*

Ref.	Quality Standard	
PE-512 BI Visit MP&S CNR Doc	**Trauma guidelines** Guidelines should be in use covering care of children with trauma, including: a. Immediate airway management b. Haemorrhage control and massive transfusion c. Chest drain insertion *Notes:* *1 This QS applies only to Emergency Departments accepting children with trauma.* *2 Guidelines on immediate airway management of children with trauma may be combined with the resuscitation and stabilisation guidelines (QS PM-505).*	
	Cross Reference CQC: 4B	*Cross Reference NHSLA: 2.8, 4.8*
PE-513 BI Visit MP&S CNR Doc	**Trauma imaging** A protocol on imaging of children with trauma should be in use which ensures: a. Where indicated, CT is the primary imaging modality b. CT scanning is undertaken within 30 minutes of arrival c. Electronic transmission of images for immediate reporting d. A provisional report is issued within one hour and communicated by telephone and electronically e. Indications and arrangements for review of imaging by a neuro-radiologist f. Full report is issued electronically within 12 hours g. Any significant variations between the provisional and final report are communicated to the senior clinician responsible for the care of the child h. Responsibilities of other services for recording receipt of imaging reports *Notes:* *1 This QS applies only to Emergency Departments accepting children with trauma.* *2 This QS links with QS PM-301.* *3 Further work is taking place on the expected speed of access to neuroradiology review and timeliness and documentation of reports. This QS may be updated when this work is completed.*	
	Cross Reference CQC: 4B, 4H	*Cross Reference NHSLA: 2.8, 4.8, 5.7*

In-Patient and High Dependency Care Services

These Standards apply to each area in the hospital providing in-patient or high dependency care for children. They are additional to the Standards found in the section headed 'Core Standards for Each Area' which should also be met. Responsibility for these Standards lies with the nominated lead consultant and nominated lead nurse (QS PM-201) for each area. Some Standards are applicable only to services providing high dependency care for children.

Ref.	Quality Standard	
Information and Support For Children And Their Families		
PQ-108 BI Visit MP&S CNR Doc	**Parent information for in-patients** Parents should be given written information about the unit, including visiting arrangements, ward routine and location of facilities within the hospital that the parents may want to use. *Note: Information should be available in formats and languages appropriate to the needs of the patients and their families.*	
	Cross Reference CQC: 1E, 1F	*Cross Reference NHSLA: 5.2*
PQ-109 BI Visit MP&S CNR Doc	**Parent facilities for in-patients** Facilities should be available for the parent of each child, including: a. Somewhere to sit away from the ward b. A quiet room for relatives c. A kitchen, toilet and washing area d. A changing area for other young children	
	Cross Reference CQC: 10A, 10I	*Cross Reference NHSLA: 4.1*
PQ-110 BI Visit MP&S CNR Doc	**Overnight facilities** Overnight facilities should be available for the parent or carer of each child, including a foldaway bed or pullout chair-bed next to the child.	
	Cross Reference CQC : 10A	*Cross Reference NHSLA: 4.1*
PQ-111 BI Visit MP&S CNR Doc	**Overnight facilities – high dependency care services** Units which provide high dependency care should have appropriate facilities for parents and carers to stay overnight, including accommodation on site but away from the ward.	
	Cross Reference CQC: 10A	*Cross Reference NHSLA: 4.1*
Staffing		
PQ-216 BI Visit MP&S CNR Doc	**High dependency care: lead consultant and lead nurse** A nominated paediatric consultant and lead nurse should have responsibility for guidelines, policies and procedures (QS PQ-601) and staff competences relating to high dependency care. The consultant should undertake Continuing Professional Development of relevance to high dependency care. The lead nurse should be a senior children's trained nurse with competences and experience in providing high dependency care. *Note:* *1 Leads may or may not be the same person as the nominated lead for the area (QS PM-201).* *2 New appointments to posts of consultant with lead responsibility for high dependency care should have achieved the 'Framework of Competences for Level 3 Training – Special Study Module in Paediatric High Dependency Care', RCPCH, 2009.*	
	Cross Reference CQC: 6C, 13A, 14A, 14B, 14G	*Cross Reference NHSLA: 1.9, 2.8, 3.5, 4.8*

Ref.	Quality Standard	
PQ-217 BI Visit MP&S CNR Doc	**Clinician with level 2 competences on duty** A clinician trained to, or training at, the equivalent of paediatric medicine and neonatal medicine (RCPCH) level 2 competences or above should be available on site at all times. *Notes:* *1 For doctors in training, this will normally be ST3 or above.* *2 RCPCH competence frameworks are available at:* ***www.rcpch.ac.uk/Training/Competency-Frameworks***	
	Cross Reference CQC: 13A, 14B, 14D, 14G	*Cross Reference NHSLA: 1.9, 2.8, 5.1*
PQ-218 BI Visit MP&S CNR Doc	**High dependency care: nursing competences** Children needing high dependency care should be cared for by a trained children's nurse with paediatric resuscitation training and competences in providing high dependency care. *Notes:* *1 Appendix 2 includes definitions of high dependency care. Appendix 6 gives details of expected resuscitation training.* *2 Appropriate courses which develop high dependency competences include:* • *Paediatric intensive care (415)* • *Neonatal intensive care (405)* • *Birmingham City University high dependency care course*	
	Cross Reference CQC: 13A, 14A, 14B	*Cross Reference NHSLA: 1.9, 3.5, 4.8*
PQ-219 BI Visit MP&S CNR Doc	**High dependency care: nurse staffing** Nurse staffing for children needing high dependency care should be 0.5:1 or 1:1 if nursed in a cubicle. If this is achieved through flexible use of staff (rather than rostering) then achievement of expected staffing levels should have been audited. *Notes:* *1 Appendix 2 includes definitions of high dependency care.* *2 In larger high dependency units, a super-numerary shift leader will also be needed.*	
	Cross Reference CQC: 13A, 14A, 14B, 16A	*Cross Reference NHSLA: 2.1, 3.5, 4.8*
PQ-220 BI Visit MP&S CNR Doc	**Tracheostomy care** If children with tracheostomies are cared for on the ward, a healthcare professional with skills in tracheostomy care should be rostered on each shift. *Notes:* *1 This QS is not applicable if children with tracheostomies are not admitted.* *2 Healthcare professionals caring for children with tracheostomies may include health care assistants who normally care for the child in the community.*	
	Cross Reference CQC : 13A, 14A, 14B	*Cross Reference NHSLA: 3.5, 4.8*
PQ-221 BI Visit MP&S CNR Doc	**High dependency care: pharmacy and physiotherapy** Wards providing high dependency care should have pharmacy and physiotherapy staff with appropriate competences and job plan time allocated for their work with children needing high dependency care. *Notes:* *1 This QS applies only to wards providing a high dependency care service for children (QS PC-601).* *2 This QS is not specific about the amount of job plan time or the competences needed.* *3 This QS is additional to the requirements in QS PM-301.*	
	Cross Reference CQC: 13A, 14A, 14B	*Cross Reference NHSLA: 1.9, 3.5, 4.8*

Ref.	Quality Standard	
SUPPORT SERVICES		
PQ-303 BI Visit MP&S CNR Doc	**Other specialties** Access to other appropriate specialties should be available, depending on the usual case mix of patients, for example, 24-hour ENT cover for tracheostomy care.	
	Cross Reference CQC: 13A	*Cross Reference NHSLA: 3.5*
PQ-304 BI Visit MP&S CNR Doc	**Intensive care support** 24-hour on-site access to a senior nurse with intensive care skills and training should be available.	
	Cross Reference CQC: 13A, 14B	*Cross Reference NHSLA: 3.5, 4.8*
FACILITIES AND EQUIPMENT		
PQ-402 BI Visit MP&S CNR Doc	**High dependency care: facilities and equipment** An appropriately designed and equipped area for providing high dependency care for children of all ages should be available. Equipment available should be appropriate for the high dependency care and interventions provided (QS PQ-601). Drugs and equipment should be checked in accordance with local policy. *Note: For in-patient wards which do not provide a high dependency care service (QS PC-601), this may be the same area as in QS PM-401.*	
	Cross Reference CQC: 9H, 10A	*Cross Reference NHSLA: 4.8, 5.4, 5.5, 5.10*
GUIDELINES, POLICIES AND PROCEDURES		
PQ-514 BI Visit MP&S CNR Doc	**High dependency care: clinical guidelines** Clinical guidelines should be in use covering the provision of high dependency care, including: a. Care of children with: i. Bronchiolitis ii. Status epilepticus iii. Diabetic ketoacidosis iv. Long-term ventilation b. High dependency interventions (QS PQ-601). c. Rehabilitation of children following trauma (if applicable) *Notes:* *1 This QS applies only to wards providing a high dependency care service for children (QS PC-601).* *2 Clinical guidelines on high dependency interventions may be combined with the Operational Policy (QS PQ-601) or may be separate.* *3 Guidelines on long-term ventilation are required only if there is a child on long-term ventilation within the local area.*	
	Cross Reference CQC: 4B	*Cross Reference NHSLA: 2.8*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
PQ-601 BI Visit MP&S CNR Doc	**High dependency care: operational policy** Wards providing high dependency care should have an operational policy covering: a. Type of children (age and diagnoses) for whom high dependency care will normally be provided b. Expected duration of high dependency care c. High dependency interventions provided, and duration of interventions, including whether the following are provided: i. Invasive monitoring ii. CPAP iii. Renal support d. Expected competences of healthcare staff providing high dependency interventions e. Arrangements for access to paediatric radiology advice f. Arrangements for liaison with lead PICU for advice and support *Notes:* *1 This QS applies only to wards providing a high dependency care service for children (QS PC-601).* *2 Clinical guidelines on high dependency interventions (QS PQ-514) may be combined with the Operational Policy or may be separate.* *3 This QS overlaps with QS PM-208 for competencies of nursing and healthcare assistant staff. Details may be given here or in QS PM-208 whichever is easier.* *Cross Reference CQC: 4B, 6A* — *Cross Reference NHSLA: 2.8*
GOVERNANCE	
PQ-701 BI Visit MP&S CNR Doc	**High dependency care: data collection** The paediatric high dependency minimum data set should be collected and submitted to SUS. *Cross Reference CQC: 4B, 16A* — *Cross Reference NHSLA: 2.1*

ANAESTHESIA AND GENERAL INTENSIVE CARE FOR CHILDREN

OBJECTIVES

- Anaesthesia for children should be delivered by practitioners with familiarity and experience of the techniques necessary to provide safe peri-operative care.
- All Anaesthetic Departments providing care for children should be clear about the limits of their expertise and have agreed guidelines to manage both elective and emergency workloads.
- The paediatric anaesthetic service should be delivered in facilities and with supporting infrastructure that is 'fit for purpose'.
- Children should be admitted to General Intensive Care Units only when it is in the best interests of the child and when there are appropriate arrangements for support and review by staff with skills and experience in the care of children and liaison with Paediatric Intensive Care staff.

Responsibility for these Standards lies with the Head of Anaesthesia / Intensive Care, the nominated lead consultant anaesthetist responsible for policies and procedures relating to children (QS PG-201), the nominated lead intensive care consultant for policies and procedures relating to children (QS PG-202), the nominated lead surgeon responsible for policies and procedures relating to children's surgery (QS PC-202), working closely with the lead consultants for each area (QS PM-201) and the Board level lead for children's services (QS PC-201).

These Standards fall within the remit of Standards PC-703 and PM-799.

Ref.	Quality Standard	
CONFIGURATION OF ANAESTHETIC / SURGICAL SERVICES		
[PC-601] BI Visit MP&S CNR Doc	**Surgery and anaesthetic services** The Trust should be clear whether it provides the following services for children and the hospital site or sites on which each service is available: a. Elective in-patient surgery for children b. Day case surgery for children c. Emergency surgery for children d. Acute pain service for children *Notes:* *1 This QS covers the anaesthetic-related aspects of QS PC-601 and is repeated here so that the Standards for Anaesthesia and General Critical Care for Children can be used separately from the other sections of these Standards.* *2 An acute pain service is expected in all hospitals providing care for children with trauma.*	
	Cross Reference CQC: 1H, 4B, 10A	
INFORMATION AND SUPPORT FOR CHILDREN AND FAMILIES		
PG-102 BI Visit MP&S CNR Doc	**Information on anaesthesia** Age-appropriate information about anaesthesia should be available for children and families. *Note: Information should be available in formats and languages appropriate to the needs of the patients and their families.*	
	Cross Reference CQC: 1A, 1E, 1G	*Cross Reference NHSLA: 2.8*

Ref.	Quality Standard	
PG-199 BI Visit MP&S CNR Doc	**Involving children and families** The service should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive b. Involving children and families in decisions about the organisation of the service *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups and/or other arrangements. They may be part of Trust-wide arrangements so long as issues relating to children's services can be identified.*	
	Cross Reference CQC: 1J, 4E, 4I	*Cross Reference NHSLA: 2.6*
STAFFING		
PG-201 BI Visit MP&S CNR Doc	**Lead anaesthetist** A nominated consultant anaesthetist should be responsible for policies and procedures relating to emergency and elective anaesthesia of children. This consultant should be involved in the delivery of anaesthetic services to children. *Note: The requirement for involvement in the delivery of anaesthetic services for children does not apply to hospital sites providing emergency services for adults and no other services for critically ill children.*	
	Cross Reference CQC: 6C, 13A, 14A, 14B, 14G	*Cross Reference NHSLA: 1.9, 3.5*
PG-202 BI Visit MP&S CNR Doc	**GICU lead consultant** A nominated lead intensive care consultant should be responsible for Intensive Care Unit policies and procedures relating to children. *Notes:* *1 The lead consultant may also be the lead anaesthetist for children (QS PG-201).* *2 This QS is not applicable if a general intensive care unit is not one of the possible areas for maintenance of intensive care (QS PM-506).*	
	Cross Reference CQC: 6C, 13A, 14A, 14B, 14G	*Cross Reference NHSLA: 1.9, 3.5*
PG-203 BI Visit MP&S CNR Doc	**Lead nurse** A nominated lead nurse should be responsible for ensuring policies, procedures and nurse training relating to children admitted to the general intensive care unit are in place. *Notes:* *1 This QS is not applicable if a general intensive care unit is not one of the possible areas for maintenance of intensive care (QS PM-506).* *2 It is desirable in all units that the lead nurse is a senior nurse with specific competences in looking after critically ill children.* *3 An example of a training programme appropriate for nurses in general intensive care units is given in Appendix 4 of the PICS Standards for the Care of Critically Ill Children.*	
	Cross Reference CQC: 6C, 13A, 14A, 14B	*Cross Reference NHSLA: 1.9, 3.5. 4.8*

Ref.	Quality Standard	
PG-204 BI Visit MP&S CNR Doc	**Medical staff caring for children** All anaesthetists or intensivists with emergency and / or elective paediatric responsibility should have up to date knowledge of advanced paediatric life support / resuscitation and stabilisation of critically ill children. *Notes:* *1 This training should comprise up to date appropriate in-house or other resuscitation and stabilisation training related to children.* *2 The Royal College of Anaesthetists 'Guidance on Paediatric Anaesthesia' (2009) states that "consultants who have no fixed paediatric lists but have to provide out-of-hours cover should undertake regular annual CME which involves supervised work with a paediatric anaesthetic colleague". Examples include supernumerary attachments to paediatric lists or secondments to specialist centres / paediatric simulator work.* *3 The role of the anaesthetic service in the care of critically ill children, including in the provision of high dependency care, should be described in QSs PM-503 to PM-509, PQ-514 and PQ-601.*	
	Cross Reference CQC: 13A, 14A, 14B, 14G	*Cross Reference NHSLA: 1.9, 3.5, 4.8*
PG-205 BI Visit MP&S CNR Doc	**Elective anaesthesia** All anaesthetists involved in the elective surgical management of children should be familiar with current practice and the techniques necessary to provide safe care for children, including acute pain management. *Note: Relevant CPD may include participation in departmental audit programmes.*	
	Cross Reference CQC: 4B, 13A, 14A, 14B, 14G	*Cross Reference NHSLA: 1.9, 3.5, 4.8*
PG-206 BI Visit MP&S CNR Doc	**Operating department assistance** Operating department assistance from personnel trained and familiar with paediatric work should be available for all emergency and elective children's surgery. For hospitals accepting children with trauma, this includes competences in the care of children with trauma. *Note: For hospitals accepting children with trauma, this QS may be achieved through work with adults with trauma as well as elective paediatric surgery, or through rotational work in a Major Trauma Centre for children.*	
	Cross Reference CQC : 13A, 14A, 14B	*Cross Reference NHSLA: 1.9, 3.5. 4.8*
PG-207 BI Visit MP&S CNR Doc	**Recovery staff** At least one member of the recovery room staff who has training and experience in paediatric practice should be available for all elective children's lists.	
	Cross Reference CQC: 13A, 14A, 14B	*Cross Reference NHSLA: 1.9, 3.5. 4.8*
FACILITIES AND EQUIPMENT		
PG-401 BI Visit MP&S CNR Doc	**Induction and recovery areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment. *Note: 'Child-friendly' should normally include visual and sound separation from adult patients.*	
	Cross Reference CQC: 9H, 10A	*Cross Reference NHSLA: 4.1, 4.8, 5.4, 5.5*

Ref.	Quality Standard	
PG-402 BI Visit MP&S CNR Doc	**Day surgery** Children needing elective surgery should be admitted to a day surgery unit or a children's ward area specifically identified for children's day surgery.	
	Cross Reference CQC: 10A	*Cross Reference NHSLA: 4.1*
PG-403 BI Visit MP&S CNR Doc	**Drugs and equipment** Appropriate drugs and equipment should be available in each area in which paediatric anaesthesia is delivered. Drugs and equipment should be checked in accordance with local policy. *Note: Appropriate drugs and equipment are listed in Appendix 7.*	
	Cross Reference CQC : 9H	*Cross Reference NHSLA: 5.10*
PG-404 BI Visit MP&S CNR Doc	**GICU paediatric area** The general intensive care unit should have an appropriately designed and equipped area for providing intensive care for children. Drugs and equipment appropriate to the age and condition of children who may be admitted (QS PM-506) should be available and checked in accordance with local policy. *Note: This QS is not applicable if a general intensive care unit is not one of the possible areas for maintenance of intensive care (QS PM-506).*	
	Cross Reference CQC: 9H, 10A	*Cross Reference NHSLA: 4.8, 5.4, 5.5, 5.10*
GUIDELINES, POLICIES AND PROCEDURES		
PG-501 BI Visit MP&S CNR Doc	**Role of anaesthetic service in care of critically ill children** Protocols for resuscitation, stabilisation, accessing advice, transfer and maintenance of critically ill children (QSs PM-503 to PM-509) and the provision of high dependency care (QS PQ-514 and PQ-601) should be clear about the role of the anaesthetic service and (general) intensive care in each stage of the child's care.	
	Cross Reference CQC: 6A, 13A, 14A, 14G	*Cross Reference NHSLA: 2.8, 4.8, 4.9*

Ref.	Quality Standard	
PG-502 BI Visit MP&S CNR Doc	**GICU Care of children** If the maintenance guidelines in QS PM-506 include the use of a general intensive care unit, they should specify: a. The circumstances under which a child will be admitted to and stay on the general intensive care unit b. A children's nurse is available to support the care of the child and should review the child at least every 12 hours c. There should be discussion with a PICU about the child's condition prior to admission and regularly during their stay on the general intensive care unit d. A local paediatrician should agree to the child being moved to the intensive care unit and should be available for advice e. A senior member of the paediatric team should review the child at least every 12 hours during their stay on the general intensive care unit *Notes:* *1 This QS is not applicable if a general intensive care unit is not one of the possible areas for maintenance of intensive care (QS PM-506).* *2 As QS PM-505 notes 1 and 2.* *3 The requirement for discussion with PICU does not apply to children aged over 16 and for whom use of adult facilities is considered appropriate.*	
	Cross Reference CQC: 4B, 6A, 6C	*Cross Reference NHSLA: 4.8*
PG-503 BI Visit MP&S CNR Doc	**Surgery criteria** Protocols should be in use covering: a. Exclusion criteria for elective and emergency surgery on children b. Day case criteria c. Non-surgical procedures requiring anaesthesia *Notes:* *1 These protocols should show consideration of children's age, clinical condition and co-morbidity and the time of day and expertise available within the hospital.* *2 These protocols should be consistent with guidance on surgical services for children.* *3 The protocols should be explicit about life-threatening situations where surgery needs to take place on site because transfer would introduce clinically inappropriate delay.*	
	Cross Reference CQC: 4A, 4B	*Cross Reference NHSLA: 2.8*
PG-504 BI Visit MP&S CNR Doc	**Clinical guidelines - anaesthesia** Clinical guidelines should be in use covering: a. Analgesia for children b. Pre-operative assessment c. Preparation of all children undergoing general anaesthesia	
	Cross Reference CQC: 4B	*Cross Reference NHSLA: 2.8, 4.8*
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES		
PG-601 BI Visit MP&S CNR Doc	**Liaison with theatre manager** There should be close liaison between the lead consultant/s for paediatric anaesthesia (QS PG-201) and the Theatre Manager with regard to the training and mentoring of support staff.	
	Cross Reference CQC: 13A, 14A, 14B, 14G	*Cross Reference NHSLA: 1.9, 3.5, 4.8, 5.1*

Ref.	Quality Standard	
PG-602 BI Visit MP&S CNR Doc	**Children's lists** Wherever possible, elective surgery on children should be undertaken on dedicated operating lists for children. If dedicated lists are not feasible, children should be put at the start of lists with appropriately trained staff in the reception, anaesthetic room, theatre and recovery areas.	
	Cross Reference CQC: 13A, 14A, 14B, 14G	*Cross Reference NHSLA: 1.9, 3.5, 4.8, 5.1*
GOVERNANCE		
PG-701 BI Visit MP&S CNR Doc	**High dependency care: data collection (GICU)** The paediatric high dependency minimum data set should be collected and submitted to SUS. *Note: This QS is not applicable if the general intensive care unit is not one of the possible areas for maintenance of intensive care (QS PM-506).*	
	Cross Reference CQC: 4B, 16A	*Cross Reference NHSLA: 2.1*

APPENDIX 1 STEERING GROUP

Name	Job Title	Organisation
Dr Charles Ralston (Chair)	Consultant Anaesthetist	Birmingham Children's Hospital NHS Foundation Trust
Dr Alistair Cranston	Consultant Anaesthetist	Birmingham Children's Hospital NHS Foundation Trust
Dr Duncan Watson	Consultant Anaesthetist (ITU)	University Hospitals Coventry & Warwickshire NHS Trust
Dr John Alexander	Clinical Director, PICU	University Hospital of North Staffordshire NHS Trust
Phil Wilson	Lead Nurse for KIDS Intensive Care and Decision Support	Birmingham Children's Hospital NHS Foundation Trust
Dr Fiona Reynolds	Consultant Intensivist	Birmingham Children's Hospital NHS Foundation Trust
Dr Ali Akbar	Consultant Paediatrician	Sandwell & West Birmingham Hospitals NHS Trust
Dr Penny Dison	Consultant Paediatrician	The Royal Wolverhampton Hospital NHS Trust
Dr James Davidson	Lead for Children's ED	University Hospitals Coventry & Warwickshire NHS Trust
Shiela Pantrini	Professional Development Lead, Emergency Directorate	Heart of England NHS Foundation Trust
Phil Jevon	Resuscitation Training Officer	Walsall Healthcare NHS Trust
Gail Fortes-Mayer	Commissioning Lead, Children's Services	Midlands and East Specialised Commissioning Group
Christine Curtis	Regional Head of Clinical Practice for Women and Children/Clinical Complaints	West Midlands Ambulance Service
Janice Llewellyn	Paediatric Ward Manager	Shrewsbury & Telford Hospitals NHS Trust
Dana Picken	Modern Matron	Worcestershire Acute Hospitals NHS Trust
Jon Cook	Programme Lead, Children's Services	NHS Midlands and East
Sue Gadd	Network Manager	Midlands Critical Care Networks
Jane Eminson	Interim Director	West Midlands Quality Review Service

Membership as at June 2012

APPENDIX 2 DEFINITIONS & ABBREVIATIONS

Children
These standards refer to the care of critically ill or critically injured children. The term 'children' refers to those aged 0 to 18 years. Young people aged 16 to 18 may sometimes be cared for in adult facilities for particular reasons, including their own preference. The special needs of these young people are not specifically mentioned in the standards but should be borne in mind.

Children's Hospital
A hospital caring only for children.

Children's Nurse is a registered nurse who has successfully completed a Registered Sick Children's Nurse (RSCN) or Registered Nurse (Child) programme which is recorded on the NMC register.

Clinician
A registered healthcare professional.

Critically ill and critically injured
The care of both critically ill and critically injured is covered by these standards. For simplicity, 'critically ill' is used throughout to refer to 'critically ill or critically injured'. These are children requiring, or potentially requiring, high dependency or intensive care whether medically, surgically or trauma-related.

Dedicated in the context of this document means individuals with no other medical or nursing commitments other than those relating to the care of critically ill children.

Guidelines, Policies, Procedures and Protocols
The Standards use the words policy, protocol, guideline and procedure based on the following definitions:

Policy:	A course or general plan adopted by a Trust, which sets out the overall aims and objectives in a particular area.
Protocol:	A document laying down in precise detail the tests/steps that must be performed.
Guidelines:	Principles which are set down to help determine a course of action. They assist the practitioner to decide on a course of action but do not need to be automatically applied. Clinical guidelines do not replace professional judgement and discretion.
Procedure:	A procedure is a method of conducting business or performing a task, which sets out a series of actions or steps to be taken.

For simplicity, some standards use the term 'policies and procedures' which should be taken as referring to policies, protocols, guidelines and procedures.

Local guidelines, policies and procedures should be based on appropriate national standards and guidance but should include consideration of implementation within the local situation. Where guidelines, policies and procedures impact on more than one service, for example, imaging, anaesthesia or Emergency Department, they should have been agreed by all the services involved.

High dependency care
The current definition of high dependency care is based on Healthcare Resource Group definitions. Refinement of this definition may follow discussions being led by the Paediatric Intensive Care Society and any revised definition should be adopted when issued.

In-patient care of children (in-patient paediatrics)
Medical and/or surgical care of children led by consultants qualified in paediatrics or paediatric intensive care, and with facilities for overnight stays. Where children are undergoing surgical care they should be under the care of a consultant paediatrician as well as consultant surgeon.

Intensive care is a service for patients with potentially recoverable, life-threatening conditions who can benefit from more detailed observation, treatment and technological support than is available in general wards and departments or high dependency facilities.

Lead PICU is the Paediatric Intensive Care Unit which is referring hospitals' normal first choice of PICU for their population.

Paediatric Intensive Care Consultant is an individual who has successfully completed approved higher training (a minimum of one year at specialist registrar level) in paediatric intensive care, who is working on the PICU and who has control over the management, admission and discharge of patients to and from the PICU. Paediatric Intensive Care consultants may not be full time and may have sessions in other specialties.

Paediatric Intensivist is a consultant who has successfully completed approved higher training (a minimum of two years at specialist registrar level) in paediatric intensive care, who works exclusively in Paediatric Intensive Care and who has control over the management, admission and discharge of patients to and from the PICU. An intensivist's non-clinical (administrative, education and research) time is also devoted to the PICU. This definition identifies individuals whose input into patient care is focussed on a specific period of the hospital stay and whose responsibility for further follow-up is minimal.

Paediatric Life Support Training / Advanced Paediatric Life Support Training is mentioned extensively in these standards. Appendix 6 gives more detail of the training appropriate for different groups of staff.

Parents
The term 'parents' is used to include mothers, fathers, carers and other adults with responsibility for caring for a child or young person.

Referring hospitals are District General Hospitals within the normal catchment population of the Retrieval Service or Paediatric Intensive Care Unit.

The following abbreviations are used within the remainder of the text:

APLS	Advanced Paediatric Life Support
ATMIST	Age, Time, Mechanism of injury, Injuries, Signs, Treatment
BI	Background information for the review team
CNR	Case note review or clinical observation
CPAP	Continuous Positive Airway Pressure
CPD	Continuing Professional Development
CQC	Care Quality Commission
CT	Computerised Tomography
Doc	Documentation should be available
ECMO	Extracorporeal membrane oxygenation
ED	Emergency Department

ENT	Ear Nose and Throat Department
EPLS	European Paediatric Life Support
GICU	General Intensive Care Unit
HDU	High Dependency Unit
HFOV	High frequency oscillatory ventilation
ICTPICM	Intercollegiate Committee for Training in Paediatric Intensive Care Medicine
ICU	Intensive Care Unit
Intraosseous	Intraosseous infusion (IO) is the process of injecting directly into the marrow of a bone to provide a non-collapsible entry point into the systemic venous system
KIDS	Kids Intensive Care and Decision Support
MP&S	Meeting patients, carers and staff
NHSLA	NHS Litigation Authority
NMC	Nursing & Midwifery Council
PEWS	Paediatric Early Warning System
PIC	Paediatric Intensive Care
PICS	Paediatric Intensive Care Society
PICU	Paediatric Intensive Care Unit
QS	Quality Standard
RCN	Royal College of Nursing
RCPCH	Royal College of Paediatrics and Child Health
RSCN/RN(Child)	Registered Children's Nurse
ST	Specialist Trainee
SUS	Secondary Uses Service
Visit	Visiting facilities

APPENDIX 3

BIBLIOGRAPHY & GENERAL GUIDANCE ON CHILDREN'S SERVICES

1. Children Act 1989, HMSO
2. The Children Act 1989 – an Introductory Guide, Department of Health.
3. The NHS and Community Care Act 1990, HMSO
4. United Nations Organisation, "The UN Convention on the Right of the Child" 1992. (CM1976) HMSO.
5. "The Allitt Inquiry" (The Clothier Report).HMSO 1994 and subsequent guidance DGM(94)26
6. Emergency Health Services for Children and Young People. Action for Sick Children 1997
7. Paediatric Intensive Care - "A Bridge to the Future". NHSE 1997
8. Paediatric Intensive Care - "Framework for the Future". NHSE 1997
9. Working Together to Safeguard Children. Department of Health 1999
10. AL(MD) 6/98: Working Time Directive agreement for career grade doctors. Advance Letter (Medical & Dental). Department of Health Nov. 1998. *http://www.dh.gov.uk/en/PublicationsAndStatistics/LettersAndCirculars/AdvancedLetters/DH_4003839*
11. Framework for the Assessment of Children in Need and their Families. DoH, Dept of Education & Employment and Home Office, 2000
12. Paediatric Intensive Care Society Standards Document. Paediatric Intensive Care Society, 2001
13. Report of the Consent Working Party. BMA, March 2001.
14. Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 – 1995. Department of Health. 2002.
15. Standards for Bereavement Care. Paediatric Intensive Care Society, 2002.
16. Defining Staffing Levels for Children's and Young People's services, Royal College of Nursing, 2003
17. Getting the right start: National Service Framework for Children. Standard for Hospital Services. Department of Health. 2003.
18. National Service Framework for Children. Emerging Findings. Department of Health. 2003.
19. National Service Framework for Children, Young People and Maternity Services, Department of Health. Department for Education and Skills, 2004
20. Children's National Service Framework for Wales. Acute and Chronic Illness or Injury. Welsh Assembly, 2005.
21. Emergency Care Framework for Children & Young People in Scotland. Scottish Executive, 2006.
22. The acutely or critically sick or injured child in the district general hospital. A team response. London: Department of Health, 2006. *('Tanner Report').*
23. 0 - 18 Years: Guidance for all Doctors, General Medical Council, 2007
24. Direction of Travel for Urgent Care: Response from the Royal College of Paediatrics and Child Health, Royal College of Paediatrics and Child Health, 2007
25. Improving Services for Children in Hospital, Commission for Healthcare Audit and Inspection, 2007

26. Modelling the Future: A consultation paper on the future of children's health services, Royal College of Paediatrics and Child Health, 2007

27. Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments. Royal College of Paediatrics and Child Health, April 2007

28. Statement on the Future Provision of General Paediatric Surgery in the District General Hospital, Children's Surgical Forum, the Royal College of Surgeons of England, Association of Paediatric Anaesthetists, the Association of Surgeons of Great Britain and Ireland, the British Association of Paediatric Surgeons, Specialist Advisory Committee in General Surgery, Specialist Advisory Committee in Paediatric Surgery, Royal College of Anaesthetists, British Association of Urological Surgeons, 2007

29. Surgery for Children - Delivering a First Class Service: Report of the Children's Surgical Forum July 2007*;* *http://www.rcseng.ac.uk/publications/docs/CSF.html*

30. Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments, Royal College of Paediatrics and Child Health, 2007

31. Supporting Paediatric Reconfiguration: A Framework for Standards, Royal College of Paediatrics and Child Health, 2008

32. Commissioning Safe & Sustainable Specialised Paediatric Services - a Framework of Critical Interdependencies, Department of Health, London, Aug 2008

33. The Role of the Consultant Paediatrician with Subspecialty Training in Paediatric Emergency Medicine, Royal College of Paediatrics and Child Health, 2008

34. Why Children Die: A Pilot Study 2006, CEMACH, 2008

35. Focus on: Children and Young People Emergency and Urgent Care Pathway NHS Institute for Innovation and Improvement, 26 June 2008

36. Guidelines for the Provision of Anaesthetic Services (Paediatric Anaesthesia & Critical Care Services Sections), The Royal College of Anaesthetists, 2009
http://www.rcoa.ac.uk/index.asp?PageID=477

37. Healthy lives, brighter future: The strategy for children and young people's health, Department for Health, Department for Children, Schools and Families, 2009

38. Improving services for children in hospital: Report of the follow-up to the 2005/06 review, Healthcare Commission, 2009

39. RCPCH guidance on the role of the consultant paediatrician in providing acute care in hospital, Royal College of Paediatrics and Child Health, 2009

40. Short Stay Paediatric Assessment Units: Advice for Commissioners and Providers, Royal College of Paediatrics and Child Health, 2009

41. A Review of Safeguards and Standards of Care" Hospital Advisory Service. WHC (99) 2 [The Secretary of State's letter contains action for all hospitals admitting children.]

42. Ensuring the Provision of General Paediatric Surgery in the District General Hospital: The Royal College of Surgeons of England - Guidance to Commissioners and Service Planners, 2010

43. Maximising Nursing Skills in Caring for Children in Emergency Departments, Royal College of Paediatrics and Child Health and Royal College of Nursing, March 2010

44. Emergency Medicine Operational Handbook: The Way Ahead, The College of Emergency Medicine, Version 2: December 2011

45. Facing the Future: A Review of Paediatric Services, Royal College of Paediatrics and Child Health, April 2011

46. Quality and Safety Standards for Small and Remote Paediatric Units, Royal College of Paediatrics and Child Health, May 2011

47. Urgent and Emergency Care Clinical Audit Toolkit, Royal College of General Practitioners, The College of Emergency Medicine and Royal College of Paediatrics and Child Health, March 2011

48. Bringing Networks to Life -An RCPCH guide to implementing Clinical Networks, Royal College of Paediatrics and Child Health, March 2012

49. Standards for Children and Young People in Emergency Care Settings, Royal College of Paediatrics and Child Health, 2012

50. The Intercollegiate Committee for Training in Paediatric Intensive Care Medicine ICTPICM). *http://www.rcoa.ac.uk/index.asp?PageID=37*

51. The Southwest Audit of Critically Ill Children (SWACIC). *http://nww.swretrieval.nhs.uk/ or http://www.picanet.org.uk/*

52. Working Time Directive. (Includes information on 'Derogation' and 26 week reference periods.) *http://www.healthcareworkforce.nhs.uk/workingtimedirective.html*

APPENDIX 4 PRESENTATION OF EVIDENCE FOR PEER REVIEW VISITS

Each Quality Standard reference column includes a box which illustrates how compliance will be reviewed.

Background information	This means that the information should be included in the background report or self assessment.
Visiting facilities	Reviewers will look for the information while they are visiting the service.
Meeting patients, carers and staff	These Standards will be discussed with patient, carers and /or staff as appropriate.
Case Note Review	A few Quality Standards require reviewers to look at case notes or other clinical information.
Documentation	These are policies, guidelines and other documentation which reviewers will need to see.

QS	Background report	Visit	Meeting Patients & Staff	Case Note review	Documentation needed	Illustration of Documentation Required
	BI	Visit	MP&S	CNR	DOC	
PC-201	X					
PC-202	X					
PC-501			X		X	**Protocol:** including transfer
PC-502		X	X		X	**Protocol:** agreed with ambulance service
PC-503			X		X	**Guidelines:** for accessing paediatric medical advice
PC-504			X		X	Evidence of trust wide agreement to exclusion criteria for emergency and elective surgery on children (PG- 501)
PC-601	X					
PC-602		X				
PC-603		X				
PC-604			X		X	Trust-wide group terms of reference
PC-703			X		X	Minutes of meeting
PC-704			X			
PM-101		X	X			
PM-102		X	X			
PM-103		X	X			
PM-104		X	X			

QS	Background report	Visit	Meeting Patients & Staff	Case Note review	Documentation needed	Illustration of Documentation Required
	BI	Visit	MP&S	CNR	DOC	
PM-105		X	X			
PM-106		X	X			
PM-108		X	X			
PM-199			X		X	Examples of children and families involvement and feedback.
PM-201	X					
PM-202	X		X			
PM-203	X		X			
PM-204	X		X			
PM-205			X		X	Training records
PM-206			X		X	Staffing rota
PM-207	X		X			
PM-208			X		X	Records of staff competences
PM-209			X		X	Staffing rota
PM-210			X		X	Staffing rota
PM-211	X		X			
PM-296			X		X	**Policy:** Staff acting outside area of competence
PM-297			X			
PM-301	X		X			
PM-401		X	X			
PM-501			X		X	**Protocol:** Initial Assessment
PM-502			X		X	**Protocol:** Paediatric advice
PM-503			X	X	X	Clinical Guidelines
PM-504			X	X	X	**Protocol:** Early warning
PM-505			X	X	X	**Protocol:** Resuscitation and stabilisation
PM-506			X	X	X	**Protocol:** PICU transfer
PM-507			X	X	X	**Protocol:** In-hospital transfer
PM-508			X	X	X	**Protocol:** High dependency care transfer
PM-509			X	X	X	**Protocol:** Transfer contingency
PM-510			X		X	**Policy:** Organ donation
PM-511			X		X	**Protocol:** Bereavement
PM-702			X		X	Audit programme or plan Examples of completed audits, action plans and monitoring.

QS	Background report	Visit	Meeting Patients & Staff	Case Note review	Documentation needed	Illustration of Documentation Required
	BI	Visit	MP&S	CNR	DOC	
PM-703			X		X	Examples of data submissions
PM-798			X		X	Documentation depends on local arrangements, for example, minutes of review and learning meetings held within the service.
PM-799			X		X	Compliance determined from other documentation presented.
PE-212	X		X			
PE-213	X					
PE-214	X					
PE-215	X		X			
PE-302		X				
PE-511			X		X	**Protocol:** Trauma
PE-512			X		X	**Guidelines:** Trauma
PE-513			X		X	**Protocol:** Imaging
PQ-108		X	X			
PQ-109		X	X			
PQ-110		X	X			
PQ-111		X	X			
PQ-216	X		X			
PQ-217	X		X			
PQ-218			X		X	Records of staffing competences
PQ-219			X		X	Staffing rotas
PQ-220			X		X	Staffing rotas and records of competences
PQ-221	X		X			
PQ-303			X			
PQ-304			X			
PQ-402		X	X			
PQ-514			X		X	**Guidelines:** High dependency care
PQ-601			X		X	Operational Policy
PQ-701					X	Evidence of data submission
[PC-601]	X					
PG-102		X	X			
PG-199			X		X	Examples of children and families involvement and feedback.

QS	Background report	Visit	Meeting Patients & Staff	Case Note review	Documentation needed	Illustration of Documentation Required
	BI	**Visit**	**MP&S**	**CNR**	**DOC**	
PG-201	X		X			
PG-202	X		X			
PG-203	X		X			
PG-204			X		X	Records of staff competences
PG-205			X			
PG-206			X		X	Staffing rotas and records of staff competences
PG-207			X		X	Staffing rotas and records of staff competences
PG-401		X	X			
PG-402		X	X			
PG-403		X	X			
PG-404		X	X			
PG-501			X		X	Clarity about role of anaesthetic service in protocols PM-503 -509, PQ514 and PQ601
PG-502			X		X	**Guidelines:** GICU Care of Children
PG-503			X		X	**Protocol:** Surgery criteria
PG-504			X		X	**Clinical Guidelines:** Anaesthesia
PG-601			X			
PG-602			X			
PG-701					X	Evidence of data submission

APPENDIX 5

FACILITIES & SUPPORT FOR FAMILIES OF CRITICALLY ILL CHILDREN

This list of recommendations represents the gold standard which should be met in Tertiary Centres containing PICUs. 'Action for Sick Children' hopes that all DGHs with a children's ward and a High Dependency Unit will strive to meet these quality standards as far as possible.

FACILITIES

Overnight facilities should be provided for the parent or carer of each child, to include all of the following:

- Somewhere for them to sit away from the ward.
- A quiet room for use by relatives whose child is critically ill.
- A kitchen, toilet and washing area together with changing facilities for other young children in the family.
- Provision for breastfeeding mothers.

Parents should not be charged for overnight accommodation. The following choices should be offered:

- A foldaway bed or pullout chair bed next to the child.
- A bed at "dressing gown" distance (so that the parent can be called quickly but has some privacy and is more likely to have a good night's sleep).
- Accommodation away from the ward. This is particularly useful for specialist units where the children have longer stays. Sometimes it is possible for both parents to stay or for whole families to come for the weekend when this kind of facility is available.
- Hostels in specialist centres for parents to stay with their children as a preparation for going home, where complex home care is needed.

SUPPORT

A family care nurse should be appointed who would lead a family support service. He or she would act as a link with the family from admission through to discharge from PICU. Liaison with the Health Visitor and Community Carers when the child leaves hospital would be an important part of this role.

A welcome pack with written information about the unit would be helpful. This should include details about ward routine and the location of facilities within the hospital which the parents might want to use such as the chapel/prayer room and cafeteria. Some parents will be from a long way away and may have particular difficulties.

CHILDREN & FAMILIES FROM MINORITY COMMUNITIES

The need for link workers, advocates and interpreters to facilitate communication and religious and cultural understanding between English speaking health care workers and non-English speaking users has long been recognised. It is not satisfactory to use untrained interpreters, whether relatives, neighbours or friends, since interpreting requires a knowledge of two languages i.e. that of the health professional and that of the patient. Untrained interpreters may unwittingly cause distress when they try to save the parents the pain and shock of serious information by not telling them the whole truth. Parents should be told about the availability of interpreters on admission.

It would be helpful if the hospital could forge links with the local minority ethnic community, religious and cultural leaders as well as outreach workers. Staff should be able to provide contact with local leaders if parents need this.

Costs

The following points should also be borne in mind:

- **Car Parking:** Special arrangements should be in place for the parents of children who are critically ill.
- **Travel Costs:** Transport could be a considerable problem for families when their child is admitted to a specialist unit outside their home area.

It is very important that parents are able to stay with their child in hospital and to visit as often as possible. Travel costs to visit children in hospital can be a major problem for some families and limit how often they can visit.

The NHS Travel Costs Scheme will refund fares of the patient and an escort for a child attending hospital where the parents are on Income Support or Family Credit but there are no arrangements to cover the cost of visiting. Visiting parents on Income Support can apply to the Social Fund but many are refused and offered a loan instead.

Action for Sick Children research has found that many families suffer financial distress as a result of visiting. Some funding can be provided by the Health Service within ambulance service contracts. Commissioners need to include the cost of visiting in their contracts for services with specialist units and arrangements for reimbursement for those in need at the hospital.

Catering

Kitchen facilities should enable parents to prepare simple meals to help reduce the expense of buying hospital food. This is also more convenient for those with siblings present. Minimum provision should include a kettle, microwave, toaster and refrigerator/freezer.

Provision of Play Services in Hospital

Children coping with health care and illness express their feelings and needs differently from adults, their behaviour may be out of character as they perhaps become withdrawn, lethargic, clinging or resistant to treatment. Many sick children, certainly those who are critically ill or injured, are not able to play without skilled adult help.

All paediatric staff can use play in their care of the sick child but the trained play specialist is able to ensure that appropriate play activities and specialist programmes of care are available to help the child's care and recovery.

Children and young people frequently have fears about what might happen to them in hospital. Play can help reduce anxiety, prepare the child for treatment and procedures, or provide distraction play during treatment. Children may need post-procedural and rehabilitation support when critical illness or injury is sudden. Trained play specialists can offer specialist programmes that address the individual needs of these children offering support and empowering families to play with children who are critically ill often on intensive care.

The National Service Framework for Children and Young People provides clear guidance on the provision of play services throughout the NHS. Many previous publications have endorsed the provision of hospital play services. The 2005/06 Health Care Commission Self Assessment Framework for Children's Services includes criteria for auditing hospital play specialists. The United Nations Convention on the Rights of the Child Article 31 states that signatories shall "Recognise the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts."

The development and implementation of a professional play service when health budgets are overstretched is often difficult, but should be viewed as vital in meeting the psychological needs of the sick child. How play services are managed within a hospital will vary with the size of the paediatric department and the budget available. The recommended level of service would be a professionally trained play specialist working on every ward and in the emergency department with their work coordinated by a play services manager who would hold the play specialist diploma and have additional training in staff management. Often this service is managed centrally and ward teams and health care professionals will refer children and young people with specific needs for support. Play provision on the ward and in the ward playroom should be provided by play assistants, trainee play specialists or nursery nurses. In this case, it is important that the ward play staff should be given regular training, particularly on the value of normalising play, developmental play and assessment and the specific needs of babies, adolescents and children with learning disabilities. Play should be available on the ward and clinical areas on a daily basis. If nursery nurses are employed on the ward, they should have protected time for play and should not be expected to juggle their play role with clinical commitments.

Children who are critically ill or injured have specific play and psychological needs that should be addressed by specialist programmes of care that are vital in meeting their overall holistic needs and their fundamental right to play.

References

1. Play for Health. Delivering and Auditing Quality in Hospital Play Services.
   Judy Walker. The National Association of Hospital Play Staff, 2006.
2. The Facilitating Role of the Play Specialist. Alison Webber.
   Paediatric Nursing **12**(7) Sept 2000
3. Convention for the Rights of the Child.
   United Nations Article 31 (1989).
   (Ratified by the UK government in 1991)

Useful Addresses

1. National Association of Hospital Play Staff
   NAHPS information Officer
   C/o Coram Family. Coram Community Campus
   49 Mecklenburgh Square. London WC1N 2QA
   www.naphs.org.uk

2. Play Therapy Association
   PO Box 98
   Amersham
   Buckinghamshire
   HP6 5BL

3. Hospital Play Staff Education Trust
   PO Box30
   Bramhall
   Stockport
   SK7 1FR

APPENDIX 6 PAEDIATRIC RESUSCITATION TRAINING AND UPDATING

PICS does not endorse any particular Course in preference, whether European Paediatric Life Support ('EPLS'- UK Resuscitation Council), or the Advanced Life Support Courses ('APLS' – Advanced Life Support Group), though the undoubted value of such courses is recognised. Paediatric Resuscitation training should be tailored for individuals' functions and working environment, taking into account existing background knowledge & skills:

STAFF GROUP	Appropriate Minimum Training
MEDICAL STAFF	
Consultant who may be on call for acute paediatrics, ED, ICU/Anaesthesia or PICU	Advanced Life Support
ST3-8 in acute paediatrics, ED, ICU/Anaesthesia or PICU	Advanced Life Support
ST1-2 in acute paediatrics, ED or ICU/Anaesthesia	One day Paediatric Life Support
Medical staff (all grades) caring for children in settings other than acute paediatrics and ED	One day Paediatric Life Support
NURSING STAFF	
Retrieval team	Advanced Life Support
Nominated Lead Nurse for an area such as HDU/ICU	Advanced Life Support
Senior Nurses on PICU/Theatres & Recovery	Advanced Life Support
Nurses in Paediatrics, ED, ICU or PICU/Theatres & Recovery	One-day Paediatric Life Support
Health care assistants	Basic Life Support

NOTES:

1. Updates: Basic Life Support should be updated yearly. Advanced Resuscitation skills should be refreshed every three/four years. Please also refer to the recommendations of any providing agencies.
2. The expected level of Advanced Life Support training can be met by courses such as APLS or EPLS. However, more may be expected from already highly qualified practitioners, so training should be tailored to the individual and identified by formal yearly Appraisal. For example, Simulation Training & Clinical Attachments may be required.
3. Paediatric Life Support training (Basic or One-day, according to the individual's role) should be undertaken within the first 20 days of working with acutely ill children. This training should be transferable between posts (and Hospitals). Advanced Life Support should be of at least 8 hours duration in total and include both lectures in recognition of ill children and practical skills training in defibrillation, basic airway management and intraosseous access. Assessment of competence should be undertaken and evidence of competence should be documented.

APPENDIX 7

DRUGS & EQUIPMENT FOR RESUSCITATION AND STABILISATION AREAS

The *KIDS* (Kids Intensive Care and Decision Support) website www.kids.bch.nhs.uk should be checked for any updates to the information detailed in this appendix. *KIDS* is the new name for the West Midlands Paediatric Retrieval Service.

Adenosine	3 mg/ml
Alprostadil (prostaglandin E1)	500 micrograms/ml
Aminophylline	25 mg/ml
Amiodarone	50 mg/ml
Antibiotics customised to local microbiology	
Atracurium	10 mg/ml
Atropine sulphate	600 micrograms/ml
Budesonide	Nebuliser solution
Calcium chloride	10%
Calcium gluconate	10%
Chlorphenamine	10 mg/ml
Dexamethasone	4mg/ml
Diazepam (intravenous)	5 mg/ml
Diazepam (rectal)	5 mg and 10 mg
Dobutamine	5 mg/ml
Dopamine	40 mg/ml
Epinephrine (adrenaline)	1:1000
Epinephrine (adrenaline)	1:10000
Flecainide	10 mg/ml
Flumezanil	100 micrograms/ml
Furosemide	10 mg/ml
Hydrocortisone	100 mg/ml
Insulin (soluble)	100 units/ml
Ketamine	10 mg/ml, 50 mg/ml
Lignocaine 1%	10 mg/ml
Lorazepam	4 mg/ml
Mannitol	10% and 20%
Midazolam	5 mg/ml
Morphine	20 mg/ml
Naloxone	400 micrograms/ml
Paraldehyde	Enema
Phenobarbitone	15 mg/ml
Phenytoin sodium	50 mg/ml

Propofol	10 mg/ml. 20mg/ml
Propranolol	1 mg/ml
Rocuronium	10 mg/ml
Salbutamol intravenous solution	1 mg/ml
Salbutamol or terbutaline	Nebuliser solution
Saline 2.7%	100 ml bags
Sodium bicarbonate	8.4%
Suxamethonium	50 mg/ml
Thiopental sodium	500 mg vials

EQUIPMENT LIST

	All areas		HDU/GICU	
	Essential	Desirable	Essential	Desirable
General Items				
Dry White board and markers	●		●	
Advanced Paediatric Life Support algorithms	●		●	
Organized emergency trolley	●		●	
Paediatric Drug Dose Guide	●		●	
Weighing scales	●		●	
Heating source (for infant warming)	●		●	
Access to cold packs (for cooling)				
Clock (with timer)	●		●	
Monitoring Equipment				
Electronic monitoring with: • ECG monitor • Pulse oximeter (adult / paediatric /neonatal probes) • Noninvasive blood pressure monitoring (infant, child, adult cuffs) • Rectal and esophageal thermometer probe(28–42ºC) • Invasive arterial and central venous pressure transducers & connections • Capnography with paediatric and adult adapters	●		●	
Otoscope, ophthalmoscope, stethoscope	●		●	
Defibrillator with paediatric paddles (0-400 joules)				
Arterial / capillary blood glucose monitor	●		●	
Access to blood gas machine	●		●	
Access to 12 lead ECG	●		●	
Airway Control/Ventilation Equipment				

	All areas		HDU/GICU	
	Essential	Desirable	Essential	Desirable
Bag-valve-mask device: paediatric (500 mL) & adult (1000 / 2000 mL) with oxygen reservoir bags	●		●	
Infant, child, and adult masks	●		●	
Oxygen delivery device with flow meter and Schrader Valve Outlet	●		●	
Clear oxygen masks, standard and non-rebreathing (neonatal, infant, child, adult)	●		●	
Nasal cannulae (infant, child, adult)	●		●	
Oral airways (sizes 0–5)	●		●	
Suction devices-catheters 6–14 FG Yankauer-tip	●		●	
Nasal airways (infant, child, adult)	●		●	
Nasogastric tubes (sizes 6-16 fr)	●		●	
Laryngoscope handles (large/small) Blades: • Macintosh 1,2,3,4 • Miller 00, 0 and 1 • Robert Shaw 1	●		●	
Endotracheal tubes + tape for securing: uncuffed (2.5-5.5), cuffed (3.0-9.0)	●		●	
Introducer Stylets for endotracheal tubes (neonatal, paediatric & adult)	●		●	
Lubricant Jelly, water soluble	●		●	
Magill forceps (large and small)	●		●	
Laryngeal masks (size 0–3)	●		●	
Bougies (neonatal, paediatric & adult)		●		●
Tracheostomy tubes (Sizes 3-6mm ID)		●		●
Oxygen / Air Blender blender	●		●	
Mechanical Ventilator/s (Infant to Adult)	●		●	
Chest drain set	●		●	
Cricoidotomy set	●		●	
Vascular Access				
Butterflies (19–25 gauge)	●		●	
Needles (18–27 gauge)	●		●	
Intraosseous needles / EZ IO	●		●	
Catheters for intravenous lines (16–24 gauge)	●		●	
IV administration sets and extension tubing with calibrated chambers	●		●	

	All areas		HDU/GICU	
	Essential	Desirable	Essential	Desirable
Volumetric Fluid Pumps	●		●	
Syringe drivers	●		●	
I.V. fluids	●		●	
Fluid Administration Warming Device		●	●	
Lumbar puncture set		●	●	
Urinary catheters: Foley 6–14 Fr	●		●	
Fracture immobilisation	●			●
Cervical Collar (hard) Various Sizes	●		●	
Head blocks & Tape	●			●
Femur & Pelvic splint	●			●
Extremity splints		●		●

APPENDIX 8 CROSS-REFERENCES TO CARE QUALITY COMMISSION AND NHS LITIGATION AUTHORITY STANDARDS

Shaded boxes show where a WMQRS Quality Standard addresses one of the Care Quality Commission's *Essential Standards of Quality and Safety*. More detail can be found against each individual Quality Standard. The table also shows links between WMQRS Quality Standards and NHSLA Risk Management Standards.

	CQC Essential Standards of Quality and Safety													
QS	Respecting and involving people who use services	Consent to care and treatment	Care and welfare of people who use services	Co-operating with other providers	Safeguarding people who use services from abuse	Cleanliness and infection control	Management of medicines	Safety and suitability of premises	Safety, availability and suitability of equipment	Requirements relating to workers	Staffing	Supporting workers	Assessing and monitoring the quality of service provision	**NHSLA Risk Management Standards 2012/2013**
	1	2	4	6	7	8	9	10	11	12	13	14	16	
PC-201				■							■			1.9
PC-202			■	■							■	■		1.1, 1.9
PC-501	■		■	■									■	4.8, 4.9
PC-502	■		■											5.2
PC-503	■		■											5.2
PC-504			■											2.8
PC-601	■		■					■						-
PC-602	■		■					■						-
PC-603	■		■											-
PC-604				■										1.4, 1.9, 2.6
PC-703			■										■	1.2
PC-704			■				■							2.2, 2.5, 2.6, 2.9
PM-101				■							■			-
PM-102								■						4.1
PM-103								■						2.8
PM-104	■													5.2
PM-105	■													5.2
PM-106	■		■											5.2
PM-108	■													-
PM-199	■		■											2.6

	CQC Essential Standards of Quality and Safety													
QS	Respecting and involving people who use services	Consent to care and treatment	Care and welfare of people who use services	Co-operating with other providers	Safeguarding people who use services from abuse	Cleanliness and infection control	Management of medicines	Safety and suitability of premises	Safety, availability and suitability of equipment	Requirements relating to workers	Staffing	Supporting workers	Assessing and monitoring the quality of service provision	**NHSLA Risk Management Standards 2012/2013**
	1	2	4	6	7	8	9	10	11	12	13	14	16	
PM-201				■							■	■		3.5
PM-202											■			-
PM-203											■			1.9
PM-204											■	■		1.9, 3.5
PM-205				■							■	■		3.5, 4.8
PM-206				■							■	■		3.5, 4.8
PM-207											■	■		3.5, 4.8
PM-208				■							■	■		1.9, 3.1, 3.2, 3.5, 4.8
PM-209				■							■	■		1.9, 3.1, 3.2, 3.5, 4.8
PM-210				■							■	■		1.9, 3.1, 3.2, 3.5, 4.8
PM-211				■							■	■		3.1, 3.2
PM-296			■											2.2, 2.6
PM-297				■	■							■		3.5
PM-301			■								■	■		3.5
PM-401							■							4.8, 5.10
PM-501				■										4.8
PM-502				■										4.8
PM-503			■											2.8
PM-504	■		■										■	2.8, 4.8
PM-505	■		■	■									■	2.8, 4.8
PM-506	■		■	■									■	4.8, 4.9
PM-507	■		■	■									■	4.8, 4.9
PM-508	■		■	■									■	4.8, 4.9
PM-509			■	■										4.8, 4.9
PM-510			■											5.2
PM-511	■	■												5.2, 5.3
PM-702			■										■	2.1
PM-703			■										■	2.1

	CQC Essential Standards of Quality and Safety													
QS	Respecting and involving people who use services	Consent to care and treatment	Care and welfare of people who use services	Co-operating with other providers	Safeguarding people who use services from abuse	Cleanliness and infection control	Management of medicines	Safety and suitability of premises	Safety, availability and suitability of equipment	Requirements relating to workers	Staffing	Supporting workers	Assessing and monitoring the quality of service provision	**NHSLA Risk Management Standards 2012/2013**
	1	2	4	6	7	8	9	10	11	12	13	14	16	
PM-798			■				■							2.1, 2.2, 2.6, 4.9
PM-799			■				■						■	1.2
PE-212											■	■		4.8
PE-213				■							■			1.9
PE-214											■	■		1.9, 3.5
PE-215											■	■		1.9, 3.5
PE-302	■		■											-
PE-511			■											2.8, 4.8
PE-512			■											2.8, 4.8
PE-513			■											2.8, 4.8, 5.7
PQ-108	■													5.2
PQ-109								■						4.1
PQ-110								■						4.1
PQ-111								■						4.1
PQ-216				■							■	■		1.9, 2.8, 3.5, 4.8
PQ-217											■	■		1.9, 2.8, 5.1
PQ-218											■	■		1.9, 3.5, 4.8
PQ-219											■	■	■	2.1, 3.5, 4.8
PQ-220											■	■		3.5, 4.8
PQ-221											■	■		1.9, 3.5, 4.8
PQ-303											■			3.5
PQ-304											■	■		3.5, 4.8
PQ-402							■	■						4.8, 5.4, 5.5, 5.10
PQ-514			■											2.8
PQ-601			■	■										2.8
PQ-701			■										■	2.1
[PC-601]	■		■					■						-
PG-102	■													2.8

	CQC Essential Standards of Quality and Safety													
QS	Respecting and involving people who use services	Consent to care and treatment	Care and welfare of people who use services	Co-operating with other providers	Safeguarding people who use services from abuse	Cleanliness and infection control	Management of medicines	Safety and suitability of premises	Safety, availability and suitability of equipment	Requirements relating to workers	Staffing	Supporting workers	Assessing and monitoring the quality of service provision	**NHSLA Risk Management Standards 2012/2013**
	1	2	4	6	7	8	9	10	11	12	13	14	16	
PG-199	■		■											2.6
PG-201				■							■	■		1.9, 3.5
PG-202				■							■	■		1.9, 3.5
PG-203				■							■	■		1.9, 3.5, 4.8
PG-204											■	■		1.9, 3.5, 4.8
PG-205			■								■	■		1.9, 3.5, 4.8
PG-206											■	■		1.9, 3.5, 4.8
PG-207											■	■		1.9, 3.5, 4.8
PG-401							■	■						4.1, 4.8, 5.4, 5.5
PG-402								■						4.1
PG-403							■							5.10
PG-404							■	■						4.8, 5.4, 5.5, 5.10
PG-501				■							■	■		2.8, 4.8, 4.9
PG-502			■	■										4.8
PG-503			■											2.8
PG-504			■											2.8, 4.8
PG-601											■	■		1.9, 3.5, 4.8, 5.1
PG-602											■	■		1.9, 3.5, 4.8, 5.1
PG-701			■										■	2.1