PICS Paediatric Intensive Care Society

Quality Standards
for the Care of Critically Ill Children

5th Edition
December 2015

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FOREWORD

I am delighted to welcome and support this 5th Edition of the Paediatric Intensive Care Society (PICS) *Standards for the Care of Critically Ill Children* which I believe will be useful for clinical staff who care for critically ill children, for their managers who have a responsibility to ensure that a safe, high-quality service is delivered, and for those who are involved in the commissioning of paediatric services. I have no doubt that effective use of these standards will improve quality of care and maximise patient outcomes.

The focus on the whole patient pathway is particularly welcome, including delivery of critical care beyond the intensive care unit, reflecting the fact that critically ill children can present in a variety of settings, to a variety of clinical teams and with a range of illness severity. The Standards have been updated to reflect the most recent guidance from a number of sources including Royal College of Paediatrics and Child Health, National Institute for Health and Care Excellence, the Children's Surgical Forum and Department of Health.

The important recommendations of RCPCH 'Facing the Future' have been incorporated and the Standards have been substantially amended to capture the recommendations of RCPCH 'High Dependency Care – Time to Move on', emphasising a hierarchy of three levels of critical care and that children who require Level 2 critical care should be cared for by medical and nursing staff with additional training and experience.

At the centre of the recommendations is the child and their family and the goal to provide them with the best care as close to their home as possible. Too often a child and family are transferred to a tertiary centre when care closer to home should be possible. This is not good for the family and it places a strain on PICU beds which are under ever increasing pressure.

The development of more robust critical care services for children will be highly dependent on improved commissioning of Level 1 and Level 2 critical care units and the development of effective paediatric critical care networks. I am particularly pleased to see new sections in the PICS Standards which focus on these two areas. Whilst the terminology used is most applicable to England I hope that many of the key recommendations will be equally relevant in Northern Ireland, Scotland and Wales.

Dr Jacqueline Cornish OBE FRCP (London) Hon FRCPCH DSc (Hon)

National Clinical Director, Children, Young People and Transition to Adulthood
Medical Directorate
NHS England

INTRODUCTION

These Quality Standards (QS) aim to improve the quality of care for 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.

These Standards have been developed through collaboration between the Paediatric Intensive Care Society (PICS), a PICS stakeholder Steering Group (Appendix 1) and the West Midlands Quality Review Service (WMQRS). They build on the previous PICS Standards for the Care of Critically Ill Children (2010) but have been updated to reflect more recent national guidance, in particular, *'High Dependency Care for Children - Time to Move On' (Royal College of Paediatrics and Child Health (RCPCH), 2014), 'Standards for Children and Young People in Emergency Care Settings' (RCPCH, 2012) and 'Facing the Future' (RCPCH, 2015).* A full list of guidance used in developing the Standards is given in Appendix 2. We have also taken the opportunity to add Standards for Paediatric Critical Care Operational Delivery Networks and for commissioners which were not included in the 2010 edition. Greater consistency in commissioning of all three levels of paediatric critical care and the development of effective clinical networks are central to the future delivery of consistent, high quality critical care for children.

Kevin Morris
Chair of Steering Group
Past-President
PICS

Peter Wilson
President
PICS

Peter-Marc Fortune
President-Elect
PICS

Yvonne Heward
Vice President
PICS

Jeff Perring
Honorary Secretary
PICS

USE OF THE STANDARDS

We hope that through the use of these Quality Standards, including for peer review visits:

1 Service quality and safety 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 (CQC) and Monitor.

These Standards can be used in a variety of ways:

Local Service Improvement

The Standards can be used by any service as a framework for their local improvement programme. Services can self-assess and then work towards meeting the Standards, supported by local governance and internal monitoring. The outcome of this work can be used as evidence for the Care Quality Commission and other external agencies. Local patient participation groups may be part of this work using, especially, the '100s' Standards which relate to 'Support for Children and their Families'. Self-assessment forms are available on the PICS website (http://picsociety.uk/) for use in local service improvement.

Commissioning (where applicable)

Commissioners can use the Standards in service specifications or for service designation and / or monitoring.

Peer Review

Peer review programmes use multi-disciplinary teams of young people, families, clinical staff, managers and commissioners (where applicable) to review compliance with the Standards and to identify related issues. Peer review is a powerful mechanism for driving local service improvement and for sharing good practice between services. Over 80% of clinical staff who act as reviewers report making improvements to their own services after taking part in a peer review visit.

Because the Standards aim to support service improvement they use the word 'should' throughout rather than 'must'. 'Must' would carry the implication that a service should be suspended or closed down if the Standard is not met. Action is needed where Standards are not met but it is usually appropriate for services to carry on functioning whilst deficiencies are addressed. For similar reasons, the Standards are not separated into 'essential' and 'desirable'. All Standards should be met and labelling some Standards as 'desirable' can lead to them being ignored.

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

Example of use of Standards for peer review:

Previous versions of the PICS Standards have been used in peer review visits to hospitals in the West Midlands since 2002. A report of each visit is produced, with a summary of findings followed by details of compliance with each Standard. Standards which are found not to be met at a peer review visit may or may not be mentioned in the main, free text report. Issues within the main report are categorised as 'good practice', 'immediate risks', 'concerns' or for 'further consideration'. Examples of these categories could include:

- *Good practice: Excellent adolescent area with decoration and information appropriate to their needs. Ward routines were later in the day than on other wards.*
- *Immediate risk: Oxygen and suction equipment was not set up ready for use which could lead to delays in their availability.*
- *Concern: Staffing levels were considered insufficient for the number and case mix of patients on the unit. Existing staff were working extra shifts to ensure safe staffing levels were maintained.*
- *Further consideration: Patient information was out of date and the layout was complex and not easy to understand.*

'Immediate risks' are notified to the hospital concerned and their commissioners within five working days and a response detailing the action taken to address or mitigate the risk is required within a further five working days. Concerns are addressed by hospitals' management and governance arrangements. Commissioners monitor whether hospital action plans have been implemented.

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.
- Major Trauma Centres for Children: Separate standards and a review process cover these services.

Critically ill and critically injured children may present in Emergency Departments (ED), Children's Assessment Services (CAS) or become critically ill whilst in in-patient (IP) children's services. Those needing an enhanced level of observation, monitoring or intervention will need to be taken to a Paediatric Critical Care Unit (PCCU). Three levels of critical care are recognised in which Levels 1 and 2 map to high dependency care and Level 3 relates to intensive care. In the Paediatric Critical Care (PCC) Healthcare Resource Group (HRG) classification Levels 1, 2 and 3 paediatric critical care are also known as follows:

Level 1 (L1) critical care:	Basic Critical Care
Level 2 (L2) critical care:	Intermediate Critical Care
Level 3 (L3) critical care:	Advanced Critical Care

Children needing intermediate or advanced critical care may need to be transferred by a Specialist Paediatric Transport Service (SPTS). Anaesthetists and / or intensivists are crucial to the resuscitation and stabilisation of critically ill children and may be involved in the provision of ongoing paediatric critical care. Some children may spend a short period of time in a General (Adult) Intensive Care Unit (GICU) while waiting for the Specialist Paediatric Transport Service or because their condition is expected to improve quickly. These services should be working together within a Paediatric Critical Care Operational Delivery Network. This network and all of the services within it will need to be commissioned to provide the level of service appropriate for the needs of their local population. The Quality Standards cover all these aspects of the pathway of care for critically ill and critically injured children.

These Quality Standards link with existing guidance and Quality Standards, in particular those around:

- Long-Term Ventilation for Children and Young People
- Children and Young People's Palliative Care
- End of Life Care
- Organ Donation
- Theatres and Anaesthetic Services
- Urgent Care Services
- Critical Care (Adults)
- Transition

PICS guidance is available on the PICS website http://picsociety.uk/ .The latest versions of WMQRS Quality Standards are available on the WMQRS website www.wmqrs.nhs.uk .

These Standards also link with detailed guidance on the care of children needing surgery, for example, *'Standards for non-specialist emergency surgical care of children',* (Royal College of Surgeons, 2015).

TERMINOLOGY

The following terms are used throughout and are key to understanding the Quality Standards. Appendix 3 gives a glossary of abbreviations used in the Standards.

Terminology	Explanation
Advanced Airway Management	Administration of anaesthetic agents to facilitate safe endotracheal intubation, including rapid sequence induction. Intubation.
Aeromedical Transport	Transport of patients by air, including by rotary and fixed wing vehicles.
Bedside care	Direct patient care delivered on a bed or trolley.
Children	The term 'child' refers to an infant, child or young person 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 Assessment Service	A service where children are clinically assessed for up to 24 hours. Children seen in the service may or may not be formally admitted to hospital. The service should be situated alongside either an Emergency Department or in-patient children's service.
Children's Nurse	A registered nurse who is recorded on the Nursing and Midwifery Council Register Sub Part 1 RN8 or RNC (or equivalent) as a 'Registered Nurse – Children'.
Clinician	A registered healthcare professional.
Commissioner	Clinical Commissioning Group or NHS England Specialist Commissioner.
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, paediatric critical care whether medically, surgically or trauma-related.
Family	Family includes parents, siblings, grandparents, extended family members or others with carer responsibility.

Terminology	Explanation
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 hospital, 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 'guidelines and protocols' 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.
Immediately available	On site and able to attend within five minutes.
In-patient care of children (in-patient paediatrics)	Medical and / or surgical care of children led by consultants qualified in paediatrics or paediatric critical care, and with facilities for overnight stays. Except in specialist children's hospitals, children undergoing surgical care should be under the care of a consultant paediatrician as well as a consultant surgeon. Hospitals with in-patient paediatric facilities should have a unit providing at least Level 1 paediatric critical care on the same hospital site.
Middle grade	A registered healthcare professional who has the competences to take decisions on behalf of the responsible consultant, calling on the consultant when required. The required 'middle grade' competences are specified in the relevant Quality Standards. This person will often be a doctor but another health care professional with advanced paediatric competences may fulfil this role if deemed able to do so by the responsible consultant.
Operational Delivery Network	A network of providers of care for critically ill and critically injured children who work together, with young people and their families and with commissioners of services (if applicable) to improve the safety and quality of care across the whole patient pathway. This may or may not have the title of 'Operational Delivery Network'.
Parents	The term 'parents' is used to include mothers, fathers, carers and other adults with responsibility for caring for a child or young person, including appointed guardians.
Paediatric	Relating to the care of infants, children and young people.

Terminology	Explanation
PAEDIATRIC CRITICAL CARE	
Paediatric Critical Care (PCC)	Paediatric critical care describes the care of children who need an enhanced level of observation, monitoring or intervention which cannot safely be delivered in general wards. '*Time to Move On'* (RCPCH, 2014) defines three levels of paediatric critical care, based on the Paediatric Critical Care Minimum Dataset (PCC MDS) and Paediatric Critical Care Healthcare Resource Groups. NOTE: There will be some children who are admitted to a Paediatric Critical Care Unit for close observation, monitoring or intervention who do not meet the current HRG definitions. The interventions that currently map to Levels 1, 2 and 3 are:
Paediatric Critical Care Level 1	**LEVEL 1: BASIC CRITICAL CARE** **Airway:** Upper airway obstruction requiring nebulised adrenaline **Breathing:** • Apnoea – recurrent • Oxygen therapy plus continuous pulse oximetry plus ECG monitoring • Nasal high flow therapy **Circulation:** • Arrhythmia requiring IV anti-arrhythmic therapy **Diagnosis:** • Severe asthma (IV bronchodilator / continuous nebulisers) • Diabetic ketoacidosis requiring continuous insulin infusion **Other:** • Reduced level of consciousness (GCS 12 or below) **and** hourly (or more frequent) GCS monitoring

Terminology	Explanation
Paediatric Critical Care Level 2	**LEVEL 2: INTERMEDIATE CRITICAL CARE** **Airway:** • Nasopharyngeal airway • Care of tracheostomy (first seven days of episode only) **Breathing:** • Non-invasive ventilation (including CPAP and BiPAP) • Long-term ventilation via a tracheostomy **Circulation:** • >80 ml/kg volume boluses • Vasoactive infusion (including inotropes and prostaglandin) • Temporary external pacing • Cardiopulmonary resuscitation in the last 24 hours **Diagnosis:** • Acute renal failure requiring dialysis or haemofiltration • Status epilepticus requiring treatment with continuous IV infusion **Monitoring:** • Invasive arterial monitoring • Central venous pressure monitoring • Intracranial monitoring / external ventricular drain **Other:** • Exchange transfusion • Intravenous thrombolysis • Extracorporeal liver support (MARS) • Plasmafiltration • Epidural infusion

Terminology	Explanation
Paediatric Critical Care Level 3	**LEVEL 3: ADVANCED CRITICAL CARE** Advanced critical care as defined in the Advanced Critical Care HRGs (1 to 5): **Advanced 1** Invasive Mechanical Ventilation (IMV) OR Non-invasive ventilation / CPAP PLUS one or more of: Vasoactive infusion — CPR in last 24 hrs >80 ml/kg volume boluses — Intravenous thrombolysis Haemofiltration — Burns >20% BSA Haemodialysis — iNO / Surfactant Peritoneal dialysis — Exchange transfusion Plasmafiltration — ICP monitoring Extracorporeal liver Support (MARS) **Advanced 2** Invasive Mechanical Ventilation PLUS one or more of: Vasoactive infusion ICP monitoring Burns 20-49% BSA Intravenous thrombolysis CPR in last 24 hrs OR Advanced Respiratory Support (ARS) (Jet ventilation or High Frequency Oscillatory Ventilation (HFOV)) **Advanced 3** Invasive Mechanical Ventilation or Advanced Respiratory Support (Jet Ventilation or HFOV) PLUS one or more of: Haemofiltration Haemodialysis Peritoneal dialysis Burns 50-79% BSA Extracorporeal liver Support (MARS) Exchange transfusion iNO Surfactant Plasmafiltration **Advanced 4** Invasive Mechanical Ventilation or Advanced Respiratory Support (Jet Ventilation or HFOV) PLUS one or more of: Burns >79% BSA >80 ml/kg volume boluses **Advanced 5** Extracorporeal membrane oxygenation (ECMO) Extracorporeal Life Support (ECLS) including Ventricular Assist Device (VAD) Aortic balloon pump

Terminology	Explanation
PAEDIATRIC CRITICAL CARE UNITS (PCCU)	
Paediatric Critical Care Unit	A discrete area within a ward or hospital where paediatric critical care is delivered.
Level 1 PCCU	A discrete area or unit where Level 1 paediatric critical care is delivered. With Paediatric Critical Care Network agreement, CPAP for bronchiolitis may be initiated or continued in a number of Level 1 Paediatric Critical Care Units.
Level 2 PCCU	A discrete area or unit where Level 1 and Level 2 paediatric critical care are delivered. Other than in specialist children's hospitals, Level 2 Units should be able to provide, as a minimum, acute (and chronic) non-invasive ventilation (both CPAP and BiPAP support) and care for children with tracheostomies and children on long-term ventilation, but should not be expected to deliver specialist Level 2 interventions such as ICP monitoring or acute renal replacement therapy. Within specialist children's hospitals, Level 2 Units may provide some or all of these additional specialist interventions.
Level 3 PCCU	A unit delivering Level 2 and Level 3 paediatric critical care (and Level 1 if required). This unit may also be called a Paediatric Intensive Care Unit (PICU).

Terminology	Explanation
PAEDIATRIC RESUSCITATION AND LIFE SUPPORT	
Paediatric Resuscitation and Life Support	For staff other than the 'Team Leader' of the Paediatric Resuscitation Team, the Standards refer to two levels of competence in paediatric resuscitation and life support. Detailed definitions of these are available from the Resuscitation Council UK or the Advanced Life Support Group UK. In summary: **Basic paediatric resuscitation and life support:** • Recognition of cardiac arrest • Basic airway management, including approach to an obstructed airway • Mouth to mouth ventilation • Chest compression **Advanced paediatric resuscitation and life support:** • As above plus: • Recognition of critical illness • Intraosseous access • Bag-mask ventilation • Defibrillation • Knowledge of advanced resuscitation algorithms • Managing the team in an emergency A number of training courses are available but specific training courses in order to achieve these competences are not described. The training needed will depend on the individual's previous experience and their role. An appropriate training plan for each individual is therefore the responsibility of the employing hospital through local governance arrangements. Assessment of competence should be undertaken and evidence of competence should be documented. The frequency of updates will depend on the frequency with which staff are required to provide paediatric resuscitation and life support. Basic paediatric resuscitation and life support competences should normally be updated yearly and advanced paediatric resuscitation and life support competences every three or four years. Staff who use these skills infrequently will need to supplement this with scenario training or clinical attachments in order to maintain their competences. Staff who use their paediatric resuscitation and life support competences on a frequent basis will require less frequent updating. These staff may not need to attend specific training courses. Evidence that competence has been maintained will still need to be provided. Monitoring through annual appraisals and Continuous Professional Development (CPD) alone will not give sufficient assurance of ongoing competence.
Referring hospitals	District General Hospitals within the normal catchment population of the Specialist Paediatric Transport Service or Level 3 Paediatric Critical Care Unit.
Specialist children's hospital	Hospital commissioned to provide several specialist children's services.
Team Leader: Paediatric Resuscitation Team	Staff who take the role of 'Team Leader' of the Paediatric Resuscitation Team (QS HW-203) should have advanced paediatric resuscitation and life support competences (defined above) and should be able to demonstrate up to date knowledge relating to paediatric resuscitation through completion of Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training or equivalent assessments of knowledge and skills.

Sections of the Quality Standards

The Quality Standards are in the following sections:

Hospital-Wide Standards

Service-specific Standards

These Standards are additional to the Hospital-Wide Standards and apply to each of the following clinical services for children:

- Emergency Department within an Emergency Centre (including those intended only for adults)
- Children's Assessment Service
- In-patient Paediatric Service
- Level 1 Paediatric Critical Care Unit (L1 PCCU)
- Level 2 Paediatric Critical Care Unit (L2 PCCU)
- Level 3 Paediatric Critical Care Unit (L3 PCCU)
- Specialist Paediatric Transport Services: These Standards apply to services commissioned to provide ground transfers, air transfers or both ground and air transfers.
- Paediatric Anaesthesia and General (Adult) Intensive Care

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.

Paediatric Critical Care Operational Delivery Network

Commissioning

Applicable Standards

The Quality Standards applicable to any hospital therefore depend on the local configuration of services. Figure 1 shows the Standards applicable to different settings and Figure 2 illustrates how this would work in different types of hospitals. In each section a few Standards may not be applicable, depending on local circumstances. These are identified in the short heading or the notes to the Standard.

The Quality Standards have been developed so that the core elements, nomenclature and numbering structure are consistent for each type of service. This will make them easier for services to use and gives the potential for direct comparison across services but appears as duplication in this full set of Standards. This duplication will disappear when services start to use the self-assessment form relating to their particular service. Self-assessment forms are available on the PICS website.

Where in-patient paediatric services and a Level 1 Paediatric Critical Care Unit are staffed and managed in an integrated way, services may wish to use the 'integrated in-patient and L1 PCCU' self-assessment which removes all duplication between these sets of Standards.

Figure 1 Applicable Standards

Service provided	Applicable Quality Standards										
	Hospital-Wide [1]	Emergency Department	Children's Assessment Service	In-patient Service	Level 1 PCCU	Level 2 PCCU	Level 3 PCCU	SPTS	Paediatric Anaesthesia & GICU[2]	Paediatric Critical Care Operational Delivery Network[1]	Commissioning [1]
Emergency Department	✓	✓							✓	✓[3]	✓
Children's Assessment Service	✓		✓						✓	✓[3]	✓
In-Patient Service	✓			✓					✓	✓	✓
Level 1 Paediatric Critical Care Unit	✓				✓				✓	✓	✓
Level 2 Paediatric Critical Care Unit	✓					✓			✓	✓	✓
Level 3 Paediatric Critical Care Unit	✓						✓			✓	✓
Specialist Paediatric Transport Service	✓							✓		✓	✓
Paediatric Anaesthesia & GICU	✓								✓	✓	✓

Notes:

1. Standards are reviewed only once for each hospital.
2. Paediatric anaesthesia and GICU Standards are reviewed once for each hospital. GICU Standards are not applicable to services in specialist children's hospitals with Level 3 PCCUs or if the hospital policy is that children and young people are not admitted to a GICU.
3. Emergency Departments and Children's Assessment Services will be part of Urgent Care Networks but should also have links with Paediatric Critical Care Networks.

Figure 2 Quality Standards Applicable in Different Hospitals

PAEDIATRIC CRITICAL CARE OPERATIONAL DELIVERY NETWORK

Applicable Standards: PCC Operational Delivery Network

HOSPITAL A:
Emergency Department
Children's Assessment Service

APPLICABLE STANDARDS:

- Hospital-Wide
- Emergency Department
- Children's Assessment Service
- Paediatric Anaesthesia & GICU
- Commissioning

HOSPITAL B:
Emergency Department
Two in-patient wards, managed & staffed together, one with L1 PCCU

APPLICABLE STANDARDS:

- Hospital-Wide
- Emergency Department
- In-patient Paediatric Service
- L1 PCCU
- Paediatric Anaesthesia & GICU
- Commissioning

HOSPITAL C:
Emergency Department
Two in-patient wards, one with L2 PCCU

APPLICABLE STANDARDS:

- Hospital-Wide
- Emergency Department
- In-patient Paediatric Service
- L2 PCCU
- Paediatric Anaesthesia & GICU
- Commissioning

TRUST WITH TWO HOSPITAL SITES:

Hospital D:
Emergency Department
Children's Assessment Service

Hospital E:
Emergency Department
Two in-patient wards, one with L2 PCCU

APPLICABLE STANDARDS:

- Hospital-Wide
- Hospital D:
  - Emergency Department
  - Children's Assessment Service
  - Paediatric Anaesthesia & GICU (may be combined with hospital E)
- Hospital E:
  - Emergency Department
  - In-patient Paediatric Service
  - L2 PCCU
  - Paediatric Anaesthesia & GICU (may be combined with hospital D)
- Commissioning

SPECIALIST HOSPITAL – ELECTIVE ADMISSIONS ONLY
One children's ward with L1 PCCU

APPLICABLE STANDARDS:

- Hospital-Wide
- In-patient Paediatric Service
- L1 PCCU
- Paediatric Anaesthesia & GICU
- Commissioning

SPECIALIST CHILDREN'S HOSPITAL:

Emergency Department
Children's Assessment Service
10 In-patient wards
Four Level 1 PCCU
Two Level 2 PCCUs
One Level 3 PCCU
SPTS

APPLICABLE STANDARDS:

- Hospital-Wide
- Emergency Department
- Children's Assessment Service
- In-patient Paediatric Service
- L1 PCCU
- L2 PCCU
- L3 PCCU
- SPTS
- Paediatric Anaesthesia & GICU
- Commissioning

STRUCTURE OF EACH STANDARD

Each Standard is structured as follows:

<table>
<tr><td>Reference Number (Ref)</td><td>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 and three digits (see below for more detail).

The reference column also includes a guide to how the Standard will be reviewed:

<table>
<tr><td>BI</td><td>Background information for the review team</td></tr>
<tr><td>Visit</td><td>Visiting facilities</td></tr>
<tr><td>MP&S</td><td>Meeting patients, carers and staff</td></tr>
<tr><td>CNR</td><td>Case note review or clinical observation</td></tr>
<tr><td>Doc</td><td>Documentation should be available. Documentation may be in the form of a website or other social media.</td></tr>
</table>

The shaded area indicates the approach that will be used to reviewing the Quality Standard. Appendix 4 summarises the evidence needed for review visits.</td></tr>
<tr><td>Quality Standard (QS)

Notes</td><td>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.</td></tr>
</table>

All Standards are cross-referenced to Care Quality Commission and National Health Service Litigation Authority (NHSLA) Standards (Appendix 5).

Chapter Letters:

The following letters for the Chapters of the Standards:

HW-	Hospital-Wide
ED-	Emergency Department
CA-	Children's Assessment Service
IP-	In-patient Paediatric Service
L1-	Level 1 Paediatric Critical Care Unit
L2-	Level 2 Paediatric Critical Care Unit
L3-	Level 3 Paediatric Critical Care Unit
T-	Specialist Paediatric Transport Service
A-	Paediatric Anaesthesia and General (Adult) Intensive Care
N-	Paediatric Critical Care Operational Delivery Network
C-	Commissioning

Topic Sections: Each section covers the following topics:

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

-700	Governance

COMMENTS ON THE QUALITY STANDARDS

The Quality Standards will be revised as new national guidance becomes available and as a result of experience of their use. Comments on the Quality Standards are welcomed and will be taken into account when they are updated. Comments should be sent to PICS@aagbi.org

More information about the Paediatric Intensive Care Society and its work is available at http://picsociety.uk/

QUALITY STANDARDS

HOSPITAL-WIDE

These Standards apply to all hospitals that provide care for critically ill children, including those providing Specialist Paediatric Transport Services. They also apply to hospitals 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 hospital. This Hospital-Wide section of the Standards covers some corporate issues, some aspects of clinical care that will be common across a hospital, and Hospital-Wide support for paediatric resuscitation.

Ref.	Quality Standard
STAFFING	
HW-201 BI Visit MP&S CNR Doc	**Board-Level Lead for Children** A Board-level lead for children's services should be identified.
HW-202 BI Visit MP&S CNR Doc	**Clinical Leads** The Board-level lead for children's services should ensure that the following leads for the care of children have been identified: a. Lead consultants and nurses for each of the areas where children may be critically ill (QS **-201) b. Lead consultant for paediatric critical care c. Lead consultant for surgery in children (if applicable) d. Lead consultant for trauma in children (if applicable) e. Lead anaesthetist for children (QS A-201) f. Lead anaesthetist for paediatric critical care (QS A-202) g. Lead GICU consultant for children (QS A-203) (if applicable) h. Lead consultant/s and lead nurse/s for the Specialist Paediatric Transport Service (QS T-201) (if applicable) i. Lead consultant and lead nurse and for safeguarding children j. Lead allied health professional for the care of critically ill children *Notes:* *1 The nominated lead consultant for paediatric critical care may be the lead clinician for a PCC service or may be another consultant.* *2 A lead surgeon is not applicable to hospitals which do not provide surgery for children. A lead consultant for trauma is not applicable to hospitals which do not receive children with trauma. A lead GICU consultant for children is not applicable in hospitals where General Intensive Care Unit staff are not involved in the assessment or management of critically ill children.* *3 If the Specialist Paediatric Transport Service provides both air and ground transport, there may be a separate lead consultant and lead nurse for ground and air transport.*

Ref.	Quality Standard
HW-203 BI Visit MP&S CNR Doc	**Hospital-Wide Group** Hospitals providing hospital services for children should have a single group responsible for the coordination and development of care of critically ill and critically injured children. The membership of this group should include all nominated leads (QS HW-202) and the Resuscitation Officer with lead responsibility for children. The accountability of the group should include the Hospital Lead for children's services (QS HW-201). The relationship of the group to the hospital's mechanisms for safeguarding children 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.*
HW-204 BI Visit MP&S CNR Doc	**Paediatric Resuscitation Team** A paediatric resuscitation team should be immediately available at all times, comprising at least three people: a. A Team Leader with up to date advanced paediatric resuscitation and life support knowledge and competences and at least Level 1 RCPCH (or equivalent) competences (QS **-203) b. A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences c. An anaesthetist, or other practitioner, with up to date competences in advanced paediatric resuscitation and life support and advanced airway management *Notes:* *1 'Immediately available' means able to attend within five minutes. Hospitals with multiple hospital sites will therefore need more than one Paediatric Resuscitation Team.* *2 Staff who take the role of 'Team Leader' of the Paediatric Resuscitation Team (QS HW-203) should have advanced paediatric resuscitation and life support competences and should be able to demonstrate up to date knowledge relating to paediatric resuscitation through completion of Advanced Paediatric Life Support or European Paediatric Life Support training or equivalent assessments of knowledge and skills.* *3 The paediatric resuscitation team may include other staff, for example, a 'runner'.* *4 Competences in advanced airway management for children of different ages may be provided by different people so long as there are robust arrangements covering children of all ages at all times. For example, paediatric medical staff may have particular expertise in neonatal airway management.* *5 Further detail of achievement and maintenance of anaesthetists' competences is given in QS A-204.*
HW-205 BI Visit MP&S CNR Doc	**Consultant Anaesthetist 24 Hour Cover** A consultant anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management who is able to attend the hospital within 30 minutes and does not have responsibilities to other hospital sites should be available 24/7. *Note: Further detail of achievement and maintenance of anaesthetists' competences is given in QS A-204.*
HW-206 BI Visit MP&S CNR Doc	**Other Clinical Areas** Staff in other clinical areas where children may be critically ill, such as imaging and paediatric out-patient departments, should have basic paediatric resuscitation and life support training. *Note: During peer review visits reviewers may decide to visit these clinical areas.*

Ref.	Quality Standard
FACILITIES AND EQUIPMENT	
HW-401 BI Visit MP&S CNR Doc	**Paediatric Resuscitation Team – Equipment** The paediatric resuscitation team should have immediate access to appropriate drugs and equipment which are checked in accordance with local policy. *Note: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
GUIDELINES AND PROTOCOLS	
HW-501 BI Visit MP&S CNR Doc	**Resuscitation and Stabilisation** Protocols should be in use covering resuscitation and stabilisation, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child *Notes:* *1 Implementation of this QS is covered by QS **-503.* *2 Arrangements for managing difficult airways may involve on-site anaesthetic or ENT services or transfer of the child.*
HW-502 BI Visit MP&S CNR Doc	**Surgery and Anaesthesia Criteria** Hospital-Wide guidelines on criteria for surgery and anaesthesia for children should be in use covering: a. Elective and emergency surgical procedures undertaken on children of different ages b. Day case criteria c. Non-surgical procedures requiring anaesthesia or conscious sedation *Notes:* *1 These guidelines should show consideration of children's age, clinical condition and co-morbidity and the time of day and expertise available within the hospital.* *2 The guidelines should be explicit about life-threatening situations where surgery needs to take place on site because transfer would introduce clinically inappropriate delay.* *3 Implementation of this QS is covered by QS **-598 and QS A-598.*

Ref.	Quality Standard
HW-598 BI Visit MP&S CNR Doc	**Hospital-Wide Guidelines** The following Hospital-Wide guidelines should be in use: a. Consent b. Organ and tissue donation c. Palliative care d. Bereavement e. Staff acting outside their area of competence covering: i. Exceptional circumstances when this may occur ii. Staff responsibilities iii. Reporting of event as an untoward clinical incident iv. Support for staff *Notes:* *1 All guidelines should specifically cover the care of children. Organ and Tissue Donation Guidelines should include transplant coordinator contact details. Bereavement Guidelines should specifically cover the death of a child and bereavement of parents, carers and siblings. This policy should specify arrangements for obtaining consent for post-mortems.* *2 'c' and 'd' do not apply to hospitals providing an emergency service for adults and no other services for children.* *3 WMQRS Quality Standards for Palliative Care of Children and Young People give further detail in relation to palliative care.* *4 Implementation of this QS is covered by QS **-598 and A-598.*
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
HW-602 BI Visit MP&S CNR Doc	**Paediatric Critical Care Operational Delivery Network Involvement** At least one representative from the hospital should attend each meeting of the Paediatric Critical Care Operational Delivery Network. Information about the work of the network should be disseminated to all staff involved in the provision of critical care for children. *Notes:* *1This QS applies only to hospitals providing paediatric critical care services.* *2 Emergency Departments and Children's Assessment Services will be part of Urgent Care Networks but should also have links with Paediatric Critical Care Networks.*

Ref.	Quality Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
ED-101 BI Visit MP&S CNR Doc	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities. *Note: The facility should have visual and, ideally, sound separation from adult patients. More detail of recommendations for the environment in emergency care settings is given in 'Standards for Children and Young People in Emergency Care Settings' (RCPCH, 2012).*
ED-102 BI Visit MP&S CNR Doc	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child *Note: The need for privacy and confidentiality for other children and families may, in some units, mean that families cannot be present during ward rounds or handovers between clinical teams.*
ED-103 BI Visit MP&S CNR Doc	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available. *Notes:* *1 Information should be written in clear, simple language and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (Department of Health (DH), 2011).* *2 Information may be in paper or electronic/e-learning formats or in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.* *3 This may be general Hospital-Wide (or equivalent) information. If so, services or clinics which are specific to one condition should be clearly identified. If the information is provided only in individual patient letters then examples of these will need to be available to reviewers.*

Ref.	Quality Standard
ED-104 BI Visit MP&S CNR Doc	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Relevant support groups and voluntary organisations *Note: As QS ED-103 notes 1 to 3.*
ED-196 BI Visit MP&S CNR Doc	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details *Notes:* *1 As QS ED-103 notes 1 to 3.* *2 Discharge information should be sent electronically to the patient's GP and other relevant healthcare professionals within 24 hours of discharge.*
ED-197 BI Visit MP&S CNR Doc	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services *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 ED-103 notes 1 to 3.*
ED-199 BI Visit MP&S CNR Doc	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups, electronic media and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to children's services can be identified.*

Ref.	Quality Standard
STAFFING	
ED-201 BI Visit MP&S CNR Doc	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.
ED-202 BI Visit MP&S CNR Doc	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children *Notes:* *1 'Available' means that the consultant can attend the unit if required.* *2 This QS is not applicable to hospital sites providing emergency services for adults and no other services for critically ill children.* *3 'If paediatric on-site support is not available, the paediatric skills of Emergency Department staff with enhanced or additional paediatric training staff should be employed' (RCPCH, 2012).*
ED-203 BI Visit MP&S CNR Doc	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be Specialist Trainee 4 (ST4) or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7. *Notes:* *1 'Immediately available' means able to attend within five minutes.* *2 RCPCH competence frameworks are available at: www.rcpch.ac.uk/Training/Competency-Frameworks. A competence framework and evidence of competences is required if this QS is met by use of non-medical staff.* *3 Staffing levels needed will depend on the size and layout of the unit, dependency of patients and ward round patterns. Exact staffing ratios will depend on case-mix, availability of nurse specialists and seniority of medical trainees.* *4 Junior medical staff should not work in Emergency Departments without direct (physically present) supervision from more senior staff (ST4 or above, or equivalent), (NHS England, 2013).*

Ref.	Quality Standard
ED-206 BI Visit MP&S CNR Doc	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS ED-208) **and** expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems *Notes:* *1 Competences should be maintained through CPD.* *2 This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for assessing maintenance of competence but details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and / or where competence may not be maintained by the individual's usual clinical practice.* *3 For compliance with this QS the service should provide:* a. *A matrix of the roles within the service, competences expected and approach to maintaining competences* b. *A training and development plan showing how competences are being achieved and maintained.* *4 Training may be delivered through a variety of mechanisms, including e-learning, Hospital-Wide training and departmental training. The network education and training programme (QS N-206) will support maintenance of competences, especially in smaller units.* *5 This QS applies to all Emergency Departments, including those accepting only 'walk in' trauma.*

Ref.	Quality Standard
ED-207 BI Visit MP&S CNR Doc	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least one registered children's nurses on duty at all times in each area *Notes:* *1 'Defining Staffing Levels for Children's and Young People's Services' (Royal College of Nursing (RCN), 2013) and 'Safer Staffing: A Guide to Care Contact Time' (NHS England, 2014) give guidance on staffing levels and competence. Staffing levels should be related to the level of care needed by the child. This will be influenced by the patient's diagnosis and complexity and severity of illness, geographical lay-out of the unit and by the nursing skill-mix and experience.* *2 Draft NICE guidance on nurse staffing in A&E departments is that "where the level of service provided does not warrant this (one registered children's nurse on each shift), at least 1 A&E nurse on each shift with education, training and competency in children's nursing.".*
ED-209 BI Visit MP&S CNR Doc	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) c. Access to dietetic service (at least 5/7) d. Access to a liaison health worker for children with mental health needs (7/7) e. Access to staff with competences in psychological support (at least 5/7) *Notes:* *1 Cover for absences of all staff should be available.* *2 At least one play specialist with a Level 4 Diploma in Specialised Play for Children and Young People, a Certificate in Hospital Play Specialism, a Foundation Degree in Healthcare Play Specialism or an equivalent qualification should provide advice and guidance to staff providing support for play, mental stimulation and distraction.* *3 'a' is not applicable to emergency services for adults only or Emergency Departments seeing fewer than 16,000 children per year. Emergency Departments seeing fewer than 16,000 children per year should however have regular advice and support from play specialists.*
ED-211 BI Visit MP&S CNR Doc	**ED Liaison Paediatrician** A nominated paediatric consultant should be responsible for liaison with the nominated Emergency Department consultant (QS ED-201). *Note: The role of the liaison paediatrician should include agreement of Emergency Department guidelines and policies and involvement in training, audit and governance activities relating to the care of children.*

Ref.	Quality Standard
ED-212 BI Visit MP&S CNR Doc	**ED Sub-speciality Trained Consultant** Emergency Departments seeing 16,000 or more child attendances per year should have a consultant with sub-specialty training in paediatric emergency medicine. *Note: This QS is applicable only to departments seeing 16,000 or more children and young people per year.*
ED-213 BI Visit MP&S CNR Doc	**Small Emergency Departments** Emergency Departments seeing fewer 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. *Notes: This QS is applicable to Emergency Departments seeing fewer than 16,000 children and young people per year, even if QS ED-212 is met. It is additional to QSs ED-202, ED-203 and ED-206 and is included because of the difficulty of maintaining competences in small departments. It is not applicable to larger Emergency Departments where staff competences are covered by QSs ED-202, ED-203 and ED-206 and where activity levels should be sufficient to ensure these competences are maintained.*
ED-214 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 b. Emergency Department senior decision-maker c. Clinician with Level 1 RCPCH competences d. General Surgeon e. Orthopaedic Surgeon f. Anaesthetist with competences in advanced airway management (QS HW-204) *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.*
ED-298 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, as agreed by the hospital and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the hospital and local Safeguarding Board *Note: This QS is included because compliance with national safeguarding requirements is essential. Detailed consideration of safeguarding arrangements is covered by other review processes.*
ED-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*

Ref.	Quality Standard
SUPPORT SERVICES	
ED-301 BI Visit MP&S CNR Doc	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the hospital should have arrangements for review of imaging by a paediatric radiologist. *Notes:* *1 Availability within one hour applies only to services receiving critically ill and critically injured children and is not applicable to services receiving elective admissions only.* *2 Arrangements for access to MRI could include on site access or access through network arrangements with another hospital.*
FACILITIES AND EQUIPMENT	
ED-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: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
ED-402 BI Visit MP&S CNR Doc	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. *Notes:* *1 Drugs and equipment for in-hospital and time-critical transfers may be different. Drugs for in-hospital and time-critical transfers may be collected so long as lists of required drugs are easily visible in or near the 'grab bag'.* *2 A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
ED-403 BI Visit MP&S CNR Doc	**Facilities for Children** At least one clinical cubicle or trolley space for every 5,000 annual child attendances should be dedicated to the care of children.
ED-406 BI Visit MP&S CNR Doc	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available. *Note: 'Easily available' means within the unit or department or nearby.*

Ref.	Quality Standard
GUIDELINES AND PROTOCOLS	
ED-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 for full assessment exceed 15 minutes.
ED-502 BI Visit MP&S CNR Doc	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.
ED-503 BI Visit MP&S CNR Doc	**Resuscitation and Stabilisation** Hospital-Wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child *Note: This QS covers implementation of QS HW-501.*
ED-504 BI Visit MP&S CNR Doc	**Paediatric Advice** Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician. *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.*

Ref.	Quality Standard
ED-505 BI Visit MP&S CNR Doc	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation *Notes:* *1 Guidelines should be clear on the roles and responsibilities of all members of the multi-disciplinary team, including anaesthetic services.* *2 Guidelines should include actions to prevent / prepare for deterioration and may link with 'early warning' guidelines (QS ED-502).* *3 Where relevant, guidelines should be specific about the care of children with developmental delay, multiple disabilities or co-morbidities.* *4 Guidelines on the treatment of trauma should be based on regional trauma guidelines.* *5 'a.v' applies only to services providing care for patients with major trauma.*
ED-506 BI Visit MP&S CNR Doc	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained *Notes:* *1 Although the Specialist Paediatric Transport Service will give advice, the management of the child remains the responsibility of the referring team until the child is transferred to the Specialist Paediatric Transport Service. It is also expected that the local paediatrician and anaesthetist will remain involved with the care of the child and support the work of the Specialist Paediatric Transport Service while on-site.* *2 The Specialist Paediatric Transport Service may be a standalone service or may be part of a L3 PCCU.* *3 The Specialist Paediatric Transport Service should be contacted for children needing ECMO or burns or other specialist critical care, even if this care is not available locally.* *4 Criteria for admission to a GICU should be consistent with the agreed network criteria (QSs N-502 & 503).*

Ref.	Quality Standard
ED-507 BI Visit MP&S CNR Doc	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required. *Note: These guidelines may be combined with QS ED-506.*
ED-508 BI Visit MP&S CNR Doc	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients 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 *Notes:* *1 Most hospitals will need to transfer children, for example for opinions, investigations and treatment. Guidelines should reflect local circumstances and should cover transfer of both stable and unstable children. The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.* *2 The guidelines may be combined with QS ED-506.*
ED-509 BI Visit MP&S CNR Doc	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS ED-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS ED-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer *Notes:* *1 This QS is linked with QS HW-598e in relation to staff acting outside their area of competence.* *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 secured and there should be no loose items in the rear cabin.* *4 The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.*

Ref.	Quality Standard
ED-510 BI Visit MP&S CNR Doc	**Trauma Guidelines** Guidelines on the care of children with trauma should be in use covering: a. Handling calls received on the dedicated trauma phone b. Alerting and activating the Trauma Team (QS ED-214) c. Handover from the pre-hospital team to the Trauma Team lead d. Responsibilities of members of the Trauma Team, including responsibility for: i. Liaison with families ii. Calling all relevant consultants iii. Safeguarding children and vulnerable adults e. Involvement of a paediatric neurosurgeon in all decisions to operate on children with traumatic brain injury f. Indications and arrangements for referral to the Major Trauma Centre for children, including referral of children needing assessment for: i. Neurosurgery ii. Vascular surgery iii. Cardiothoracic surgery iv. Spinal cord service v. Specialist paediatric surgery vi. Other specialist surgery g. Handover of children no longer needing the care of the Trauma Team h. Completing standardised documentation i. Major incidents *Notes:* *1 This QS applies only to Emergency Departments accepting children with trauma.* *2 Guidelines may be combined with the adult trauma guidelines.* *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 (Age, Time, Mechanism of injury, Injuries, Signs, Treatment) or equivalent system should be used for handover from the pre-hospital team*.
ED-511 BI Visit MP&S CNR Doc	**Trauma Clinical Guidelines** Guidelines should be in use covering the care of children with trauma, including: a. Immediate airway management b. Haemorrhage control and massive transfusion c. Chest drain insertion *Notes:* *1 This QS applies to all Emergency Departments, including those accepting only 'walk-in' children with trauma.* *2 Guidelines on immediate airway management of children with trauma may be combined with the resuscitation and stabilisation guidelines (QS ED-503).*

Ref.	Quality Standard
ED-512 BI Visit MP&S CNR Doc	**Trauma Imaging Guidelines** Guidelines on imaging of children with trauma should be in use covering at least: a. Imaging modalities and indications b. Liaison with a radiologist to agree an imaging plan c. Timescales for undertaking imaging d. Indications and arrangements for review of imaging by a neuro-radiologist e. Timescales for provisional and final reporting f. Electronic transmission of images g. Responsibilities for recording receipt of imaging reports h. Monitoring achievement of expected timescales: i. CT scanning within 30 minutes of arrival ii. Provisional report issued within one hour iii. Full report issued within 12 hours i. Communication of any significant variations between the provisional and final reporting *Notes:* *1 This QS applies only to Emergency Departments accepting children with trauma.* *2 This QS links with QS ED-301.*
ED-598 BI Visit MP&S CNR Doc	**Implementation of Hospital Guidelines** Staff should be aware of and following hospital guidelines (QS HW-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence *Note: This QS covers implementation of QS HW-598. Documentary evidence is not required for compliance with this QS. 'a' applies only to clinical areas caring for children requiring surgery.*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
ED-601 BI Visit MP&S CNR Doc	**Operational Policy** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate *Notes:* *1 Individualised management plans may be in the form of patient passports.* *2 Notifying other relevant members of the primary health care team is desirable.* *3 Operational policies should be based on the inclusion and exclusion criteria, interventions and key performance indicators for which the service is commissioned (QS C-603). Operational policies should be clear about the care of young people aged 16 to 18 and pre-term babies discharged from neonatal units.* *4 RCPCH (2015) recommends that units work towards consultant presence 12 hours a day, seven days a week.*
ED-602 BI Visit MP&S CNR Doc	**Urgent Care Centres** If the hospital's services include an Urgent Care Centre, this Centre should have: a. At least one clinician with advanced paediatric resuscitation and life support competences is available on site at all times the service is open b. Appropriate drugs and equipment for a paediatric resuscitation, including a defibrillator, oxygen and suction c. Guidelines in use in the event of a critically ill child, or potentially critically ill child, presenting. The guidelines should include transfer to an appropriate paediatric unit *Notes:* *1 This QS applies only to Urgent Care Centres. These are defined in 'Transforming urgent and emergency care services in England' (NHS England, 2014) and may previously have been called Minor Injuries Units or Walk-in Centres.* *2 The defibrillator may be an automated external defibrillator.*
ED-603 BI Visit MP&S CNR Doc	**Emergency Centres for Adults Only – Avoiding Child Attendances** Hospitals without on-site assessment or in-patient services for children should: a. Indicate clearly to the public the nature of the service provided for children b. Have agreed a protocol with the local ambulance service that children are not brought to the service by ambulance c. Have arrangements for accessing paediatric medical advice and appropriate anaesthetic input to the care of a child *Note: This QS applies only to hospitals providing an Emergency Department for adults only. ED- Standards still apply, including those relating to time-critical transfers (QS ED-509).*

Ref.	Quality Standard
GOVERNANCE	
ED-701 BI Visit MP&S CNR Doc	**Data Collection** The service should collect and submit Trauma Audit Research Network data and should review their performance compared with other units on a regular basis. *Note: This QS applies to hospitals accepting trauma only.*
ED-703 BI Visit MP&S CNR Doc	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS ED-500s) b. Participation in agreed national and network-wide audits c. Use of the *'Urgent and Emergency Care Clinical Audit Toolkit'* to review individual clinical consultations *Note: The rolling programme should ensure that action plans are developed following audits and their implementation is monitored.*
ED-704 BI Visit MP&S CNR Doc	**Key Performance Indicators** Key performance indicators should be reviewed regularly with hospital (or equivalent) management and with commissioners.
ED-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'. *Notes:* *1 These arrangements should include feedback to operational staff and should link with Hospital-Wide governance arrangements.* *2 This QS is additional to Paediatric Critical Care Network review and learning (QS N-798).* *3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.*
ED-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines and should comply with hospital document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

CHILDREN'S ASSESSMENT SERVICES

Ref.	Quality Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
CA-101 BI Visit MP&S CNR Doc	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities. *Note: The facility should have visual and, ideally, sound separation from adult patients. More detail of recommendations for the environment in emergency care settings is given in 'Standards for Children and Young People in Emergency Care Settings' (RCPCH, 2012).*
CA-102 BI Visit MP&S CNR Doc	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child *Note: The need for privacy and confidentiality for other children and families may, in some units, mean that families cannot be present during ward rounds or handovers between clinical teams.*
CA-103 BI Visit MP&S CNR Doc	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available. *Notes:* *1 Information should be written in clear, simple language and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (DH, 2011).* *2 Information may be in paper or electronic/e-learning formats or in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.* *3 This may be general Hospital-Wide (or equivalent) information. If so, services or clinics which are specific to one condition should be clearly identified. If the information is provided only in individual patient letters then examples of these will need to be available to reviewers.*

Ref.	Quality Standard
CA-104 BI Visit MP&S CNR Doc	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Layout of the unit or ward, visiting arrangements including arrangements for children to visit, car parking advice, ward routines and location of facilities within the hospital that families may wish to use g. Relevant support groups and voluntary organisations *Note: As QS CA-103 notes 1 to 3.*
CA-196 BI Visit MP&S CNR Doc	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details *Notes:* *1 As QS CA-103 notes 1 to 3.* *2 Discharge information should be sent electronically to the patient's GP and other relevant healthcare professionals within 24 hours of discharge.*
CA-197 BI Visit MP&S CNR Doc	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services *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 CA-103 notes 1 to 3.*
CA-199 BI Visit MP&S CNR Doc	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups, electronic media and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to children's services can be identified.*

Ref.	Quality Standard
STAFFING	
CA-201 BI Visit MP&S CNR Doc	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.
CA-202 BI Visit MP&S CNR Doc	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children *Note: 'Available' means that the consultant can attend the unit if required.*
CA-203 BI Visit MP&S CNR Doc	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7. *Notes:* *1 'Immediately available' means able to attend within five minutes.* *2 RCPCH competence frameworks are available at: www.rcpch.ac.uk/Training/Competency-Frameworks. A competence framework and evidence of competences is required if this QS is met by use of non-medical staff.* *3 Staffing levels needed will depend on the size and layout of the unit, dependency of patients and ward round patterns. Exact staffing ratios will depend on case-mix, availability of nurse specialists and seniority of medical trainees.*

Ref.	Quality Standard
CA-206 BI Visit MP&S CNR Doc	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS CA-208) **and** expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems *Notes:* *1 Competences should be maintained through CPD.* *2 This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for assessing maintenance of competence but details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and / or where competence may not be maintained by the individual's usual clinical practice.* *3 For compliance with this QS the service should provide:* a. *A matrix of the roles within the service, competences expected and approach to maintaining competences* b. *A training and development plan showing how competences are being achieved and maintained.* *4 Training may be delivered through a variety of mechanisms, including e-learning, Hospital-Wide training and departmental training. The network education and training programme (QS N-206) will support maintenance of competences, especially in smaller units.*
CA-207 BI Visit MP&S CNR Doc	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area *Note: 'Defining Staffing Levels for Children's and Young People's Services' (RCN, 2013) and 'Safer Staffing: A Guide to Care Contact Time' (NHS England, 2014) give guidance on staffing levels and competence. Staffing levels should be related to the level of care needed by the child. This will be influenced by the patient's diagnosis and complexity and severity of illness, geographical lay-out of the unit and by the nursing skill-mix and experience.*

Ref.	Quality Standard
CA-209 BI Visit MP&S CNR Doc	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) c. Access to dietetic service (at least 5/7) d. Access to a liaison health worker for children with mental health needs (7/7) e. Access to staff with competences in psychological support (at least 5/7) *Notes:* *1 Cover for absences of all staff should be available.* *2 At least one play specialist with a Level 4 Diploma in Specialised Play for Children and Young People, a Certificate in Hospital Play Specialism, a Foundation Degree in Healthcare Play Specialism or an equivalent qualification should provide advice and guidance to staff providing support for play, mental stimulation and distraction.*
CA-298 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, as agreed by the hospital and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the hospital and local Safeguarding Board *Note: This QS is included because compliance with national safeguarding requirements is essential. Detailed consideration of safeguarding arrangements is covered by other review processes.*
CA-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*
SUPPORT SERVICES	
CA-301 BI Visit MP&S CNR Doc	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the hospital should have arrangements for review of imaging by a paediatric radiologist. *Notes:* *1 Availability within one hour applies only to services receiving critically ill and critically injured children and is not applicable to services receiving elective admissions only.* *2 Arrangements for access to MRI could include on site access or access through network arrangements with another hospital.*

Ref.	Quality Standard
FACILITIES AND EQUIPMENT	
CA-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: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
CA-402 BI Visit MP&S CNR Doc	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. *Notes:* *1 Drugs and equipment for in-hospital and time-critical transfers may be different. Drugs for in-hospital and time-critical transfers may be collected so long as lists of required drugs are easily visible in or near the 'grab bag'.* *2 A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
CA-406 BI Visit MP&S CNR Doc	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available. *Note: 'Easily available' means within the unit or department or nearby.*
GUIDELINES AND PROTOCOLS	
CA-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 for full assessment exceed 15 minutes.
CA-502 BI Visit MP&S CNR Doc	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.
CA-503 BI Visit MP&S CNR Doc	**Resuscitation and Stabilisation** Hospital-Wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child *Note: This QS covers implementation of QS HW-501.*

Ref.	Quality Standard
CA-504 BI Visit MP&S CNR Doc	**Paediatric Advice** Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician. *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.*
CA-505 **BI** **Visit** MP&S CNR Doc	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) *Notes:* *1 Guidelines should be clear on the roles and responsibilities of all members of the multi-disciplinary team, including anaesthetic services.* *2 Guidelines should include actions to prevent / prepare for deterioration and may link with 'early warning' guidelines (QS CA-502).* *3 Where relevant, guidelines should be specific about the care of children with developmental delay, multiple disabilities or co-morbidities.*

Ref.	Quality Standard
CA-506 BI Visit MP&S CNR Doc	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained *Notes:* *1 Although the Specialist Paediatric Transport Service will give advice, the management of the child remains the responsibility of the referring team until the child is transferred to the Specialist Paediatric Transport Service. It is also expected that the local paediatrician and anaesthetist will remain involved with the care of the child and support the work of the Specialist Paediatric Transport Service while on-site.* *2 The Specialist Paediatric Transport Service may be a standalone service or may be part of a L3 PCCU.* *3 The Specialist Paediatric Transport Service should be contacted for children needing ECMO or burns or other specialist critical care, even if this care is not available locally.* *4 Criteria for admission to a GICU should be consistent with the agreed network criteria (QSs N-502 & 503).*
CA-507 BI Visit MP&S CNR Doc	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required. *Note: These guidelines may be combined with QS CA-506.*
CA-508 BI Visit MP&S CNR Doc	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients 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 *Notes:* *1 Most hospitals will need to transfer children, for example for opinions, investigations and treatment. Guidelines should reflect local circumstances and should cover transfer of both stable and unstable children. The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.* *2 The guidelines may be combined with QS CA-506.*

Ref.	Quality Standard
CA-509 BI Visit MP&S CNR Doc	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS CA-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS CA-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer *Notes:* *1 This QS is linked with QS HW-598e in relation to staff acting outside their area of competence.* *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 secured and there should be no loose items in the rear cabin.* *4 The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.*
CA-598 BI Visit MP&S CNR Doc	**Implementation of Hospital Guidelines** Staff should be aware of and following hospital guidelines (QS HW-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence *Note: This QS covers implementation of QS HW-598. Documentary evidence is not required for compliance with this QS. 'a' applies only to clinical areas caring for children requiring surgery.*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
CA-601 BI Visit MP&S CNR Doc	**Operational Policy** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for a consultant-led rapid access service which can see children within 24 hours of referral g. Arrangements for admission within four hours of the decision to admit h. Types of patient admitted i. Review by a senior clinician within four hours of admission j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff l. Discussion with a senior clinician prior to discharge *Notes:* *1 Individualised management plans may be in the form of patient passports.* *2 Notifying other relevant members of the primary health care team is desirable.* *3 Operational policies should be based on the inclusion and exclusion criteria, interventions and key performance indicators for which the service is commissioned (QS C-603). Operational policies should be clear about the care of young people aged 16 to 18 and pre-term babies discharged from neonatal units.* *4 RCPCH (2015) recommends that units work towards consultant presence 12 hours a day, seven days a week.*
GOVERNANCE	
CA-703 BI Visit MP&S CNR Doc	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS CA-500s) b. Participation in agreed national and network-wide audits c. Use of the *'Urgent and Emergency Care Clinical Audit Toolkit'* to review individual clinical consultations *Note: The rolling programme should ensure that action plans are developed following audits and their implementation is monitored.*
CA-704 BI Visit MP&S CNR Doc	**Key Performance Indicators** Key performance indicators should be reviewed regularly with hospital (or equivalent) management and with commissioners.

Ref.	Quality Standard
CA-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'. *Notes:* *1 These arrangements should include feedback to operational staff and should link with Hospital-Wide governance arrangements.* *2 This QS is additional to Paediatric Critical Care Network review and learning (QS N-798).* *3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.*
CA-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines and should comply with hospital document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

IN-PATIENT PAEDIATRIC SERVICES

Ref.	Quality Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
IP-101 BI Visit MP&S CNR Doc	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities. *Note: The facility should have visual and, ideally, sound separation from adult patients. More detail of recommendations for the environment in emergency care settings is given in 'Standards for Children and Young People in Emergency Care Settings' (RCPCH, 2012).*
IP-102 BI Visit MP&S CNR Doc	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child *Note: The need for privacy and confidentiality for other children and families may, in some units, mean that families cannot be present during ward rounds or handovers between clinical teams.*
IP-103 BI Visit MP&S CNR Doc	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available. *Notes:* *1 Information should be written in clear, simple language and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (DH, 2011).* *2 Information may be in paper or electronic/e-learning formats or in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.* *3 This may be general Hospital-Wide (or equivalent) information. If so, services or clinics which are specific to one condition should be clearly identified. If the information is provided only in individual patient letters then examples of these will need to be available to reviewers.*

Ref.	Quality Standard
IP-104 BI Visit MP&S CNR Doc	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Layout of the unit or ward, visiting arrangements including arrangements for children to visit, car parking advice, ward routines and location of facilities within the hospital that families may wish to use g. Relevant support groups and voluntary organisations *Note: As QS IP-103 notes 1 to 3.*
IP-105 BI Visit MP&S CNR Doc	**Facilities and Support for Families** Facilities should be available for families, including: a. Somewhere to sit away from the ward b. Quiet room for relatives c. Kitchen, toilet and washing area d. Changing area for other young children e. Midwifery and breast feeding support f. Breast feeding facilities g. Chair for parents to sit next to the child h. Access to psychological support *Notes:* *1 'e' is applicable only to services which admit neonates.* *2 Support for families should be sensitive to their cultural and faith needs.*
IP-196 BI Visit MP&S CNR Doc	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details *Notes:* *1 As QS IP-103 notes 1 to 3.* *2 Discharge information should be sent electronically to the patient's GP and other relevant healthcare professionals within 24 hours of discharge.* *3 More detail on discharge of children with long-term ventilation is given in the WMQRS Quality Standards for services providing Long-Term Ventilation for Children and Young People.*

Ref.	Quality Standard
IP-197 BI Visit MP&S CNR Doc	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services *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 IP-103 notes 1 to 3.*
IP-199 BI Visit MP&S CNR Doc	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups, electronic media and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to children's services can be identified.*
STAFFING	
IP-201 BI Visit MP&S CNR Doc	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.
IP-202 BI Visit MP&S CNR Doc	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children *Notes:* *1 'Available' means that the consultant can attend the unit if required.* *2 'Facing the Future: A Review of Paediatric Services' (RCPCH, 2015) recommends that 'all general acute paediatric rotas are made up of at least 10 WTEs all of which are EWTD compliant'.*

Ref.	Quality Standard
IP-203 BI Visit MP&S CNR Doc	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7. *Notes:* *1 'Immediately available' means able to attend within five minutes.* *2 RCPCH competence frameworks are available at: www.rcpch.ac.uk/Training/Competency-Frameworks. A competence framework and evidence of competences is required if this QS is met by use of non-medical staff.* *3 Staffing levels needed will depend on the size and layout of the unit, dependency of patients and ward round patterns. Exact staffing ratios will depend on case-mix, availability of nurse specialists and seniority of medical trainees.*
IP-205 BI Visit MP&S CNR Doc	**Medical Staff: Continuity of Care** Consultant rotas should be organised to give reasonable continuity of care. *Note: 'Continuity of care' normally means cover by the same consultant for a minimum of three weekdays in succession. RCPCH (2015) recommends that 'all general paediatric inpatient units adopt an attending consultant system most often in the form of the 'consultant of the week' system'.*

Ref.	Quality Standard
IP-206 BI Visit MP&S CNR Doc	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS IP-208) **and** expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems *Notes:* *1 Competences should be maintained through CPD.* *2 This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for assessing maintenance of competence but details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and / or where competence may not be maintained by the individual's usual clinical practice.* *3 For compliance with this QS the service should provide:* a. *A matrix of the roles within the service, competences expected and approach to maintaining competences* b. *A training and development plan showing how competences are being achieved and maintained.* *4 Training may be delivered through a variety of mechanisms, including e-learning, Hospital-Wide training and departmental training. The network education and training programme (QS N-206) will support maintenance of competences, especially in smaller units.* *5 'd' applies to general paediatric wards and not to specialty-specific wards or those accepting only elective admissions.*
IP-207 BI Visit MP&S CNR Doc	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area *Note: 'Defining Staffing Levels for Children's and Young People's Services' (RCN, 2013) and 'Safer Staffing: A Guide to Care Contact Time' (NHS England, 2014) give guidance on staffing levels and competence. Staffing levels should be related to the level of care needed by the child. This will be influenced by the patient's diagnosis and complexity and severity of illness, geographical lay-out of the unit and by the nursing skill-mix and experience.*

Ref.	Quality Standard
IP-209 BI Visit MP&S CNR Doc	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. Access to a liaison health worker for children with mental health needs (7/7) c. Access to staff with competences in psychological support (at least 5/7) d. Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit) e. Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit) f. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) g. Access to dietetic service (at least 5/7) h. Access to an educator for the training, education and continuing professional development of staff *Notes:* *1 Cover for absences of all staff should be available.* *2 At least one play specialist with a Level 4 Diploma in Specialised Play for Children and Young People, a Certificate in Hospital Play Specialism, a Foundation Degree in Healthcare Play Specialism or an equivalent qualification should provide advice and guidance to staff providing support for play, mental stimulation and distraction.*
IP-298 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, as agreed by the hospital and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the hospital and local Safeguarding Board *Note: This QS is included because compliance with national safeguarding requirements is essential. Detailed consideration of safeguarding arrangements is covered by other review processes.*
IP-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*
SUPPORT SERVICES	
IP-301 BI Visit MP&S CNR Doc	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the hospital should have arrangements for review of imaging by a paediatric radiologist. *Notes:* *1 Availability within one hour applies only to services receiving critically ill and critically injured children and is not applicable to services receiving elective admissions only.* *2 Arrangements for access to MRI could include on site access or access through network arrangements with another hospital.*

Ref.	Quality Standard
FACILITIES AND EQUIPMENT	
IP-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: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
IP-402 BI Visit MP&S CNR Doc	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. *Notes:* *1 Drugs and equipment for in-hospital and time-critical transfers may be different. Drugs for in-hospital and time-critical transfers may be collected so long as lists of required drugs are easily visible in or near the 'grab bag'.* *2 A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
IP-406 BI Visit MP&S CNR Doc	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available. *Note: 'Easily available' means within the unit or department or nearby.*
GUIDELINES AND PROTOCOLS	
IP-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 for full assessment exceed 15 minutes. *Note: This QS is not applicable to services which take only elective admissions.*
IP-502 BI Visit MP&S CNR Doc	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.
IP-503 BI Visit MP&S CNR Doc	**Resuscitation and Stabilisation** Hospital-Wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child *Note: This QS covers implementation of QS HW-501.*

Ref.	Quality Standard
IP-504 BI Visit MP&S CNR Doc	**Paediatric Advice** Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician. *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.*
IP-505 **BI** **Visit** MP&S CNR Doc	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) j. Rehabilitation after critical illness (if applicable) *Notes:* *1 Guidelines should be clear on the roles and responsibilities of all members of the multi-disciplinary team, including anaesthetic services.* *2 Guidelines should include actions to prevent / prepare for deterioration and may link with 'early warning' guidelines (QS IP-502).* *3 Where relevant, guidelines should be specific about the care of children with developmental delay, multiple disabilities or co-morbidities.* *4 Guidelines on the treatment of trauma should be based on regional trauma guidelines.* *5 'a.v' applies only to services providing care for patients with major trauma.*

Ref.	Quality Standard
IP-506 BI Visit MP&S CNR Doc	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained *Notes:* *1 Although the Specialist Paediatric Transport Service will give advice, the management of the child remains the responsibility of the referring team until the child is transferred to the Specialist Paediatric Transport Service. It is also expected that the local paediatrician and anaesthetist will remain involved with the care of the child and support the work of the Specialist Paediatric Transport Service while on-site.* *2 The Specialist Paediatric Transport Service may be a standalone service or may be part of a L3 PCCU.* *3 The Specialist Paediatric Transport Service should be contacted for children needing ECMO or burns or other specialist critical care, even if this care is not available locally.* *4 Criteria for admission to a GICU should be consistent with the agreed network criteria (QSs N-502 & 503).*
IP-507 BI Visit MP&S CNR Doc	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required. *Note: These guidelines may be combined with QS IP-506.*
IP-508 BI Visit MP&S CNR Doc	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients 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 *Notes:* *1 Most hospitals will need to transfer children, for example for opinions, investigations and treatment. Guidelines should reflect local circumstances and should cover transfer of both stable and unstable children. The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.* *2 The guidelines may be combined with QS IP-506.*

Ref.	Quality Standard
IP-509 BI Visit MP&S CNR Doc	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS IP-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS IP-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer *Notes:* *1 This QS is linked with QS HW-598e in relation to staff acting outside their area of competence.* *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 secured and there should be no loose items in the rear cabin.* *4 The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.*
IP-598 BI Visit MP&S CNR Doc	**Implementation of Hospital Guidelines** Staff should be aware of and following hospital guidelines (QS HW-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence *Note: This QS covers implementation of QS HW-598. Documentary evidence is not required for compliance with this QS. 'a' applies only to clinical areas caring for children requiring surgery.*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
IP-601 BI Visit MP&S CNR Doc	**Operational Policy** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for a consultant-led rapid access service which can see children within 24 hours of referral g. Arrangements for admission within four hours of the decision to admit h. Types of patient admitted i. Review by a senior clinician within four hours of admission j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff l. Discussion with a senior clinician prior to discharge *Notes:* *1 Individualised management plans may be in the form of patient passports.* *2 Notifying other relevant members of the primary health care team is desirable.* *3 Operational policies should be based on the inclusion and exclusion criteria, interventions and key performance indicators for which the service is commissioned (QS C-603). Operational policies should be clear about the care of young people aged 16 to 18 and pre-term babies discharged from neonatal units.* *4 RCPCH (2015) recommends that units work towards consultant presence 12 hours a day, seven days a week.*
GOVERNANCE	
IP-703 BI Visit MP&S CNR Doc	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS IP-500s) b. Participation in agreed national and network-wide audits c. Use of the *'Urgent and Emergency Care Clinical Audit Toolkit'* to review individual clinical consultations *Notes:* *1 The rolling programme should ensure that action plans are developed following audits and their implementation is monitored.* *2 'c' is not applicable to In-patient and L1 PCCUs which do not accept direct GP referrals.*
IP-704 BI Visit MP&S CNR Doc	**Key Performance Indicators** Key performance indicators should be reviewed regularly with hospital (or equivalent) management and with commissioners.

Ref.	Quality Standard
IP-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'. *Notes:* *1 These arrangements should include feedback to operational staff and should link with Hospital-Wide governance arrangements.* *2 This QS is additional to Paediatric Critical Care Network review and learning (QS N-798).* *3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.*
IP-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines and should comply with hospital document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

LEVEL 1 PAEDIATRIC CRITICAL CARE UNITS

Ref.	Quality Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
L1-101 BI Visit MP&S CNR Doc	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities. *Note: The facility should have visual and, ideally, sound separation from adult patients. More detail of recommendations for the environment in emergency care settings is given in 'Standards for Children and Young People in Emergency Care Settings' (RCPCH, 2012).*
L1-102 BI Visit MP&S CNR Doc	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child *Note: The need for privacy and confidentiality for other children and families may, in some units, mean that families cannot be present during ward rounds or handovers between clinical teams.*
L1-103 BI Visit MP&S CNR Doc	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available. *Notes:* *1 Information should be written in clear, simple language and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (DH, 2011).* *2 Information may be in paper or electronic/e-learning formats or in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.* *3 This may be general Hospital-Wide (or equivalent) information. If so, services or clinics which are specific to one condition should be clearly identified. If the information is provided only in individual patient letters then examples of these will need to be available to reviewers.*

Ref.	Quality Standard
L1-104 BI Visit MP&S CNR Doc	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Layout of the unit or ward, visiting arrangements including arrangements for children to visit, car parking advice, ward routines and location of facilities within the hospital that families may wish to use g. Relevant support groups and voluntary organisations *Note: As QS L1-103 notes 1 to 3.*
L1-105 BI Visit MP&S CNR Doc	**Facilities and Support for Families** Facilities should be available for families, including: a. Somewhere to sit away from the ward b. Quiet room for relatives c. Kitchen, toilet and washing area d. Changing area for other young children e. Midwifery and breast feeding support f. Breast feeding facilities g. Chair for parents to sit next to the child h. Access to psychological support *Notes:* *1 'e' is applicable only to services which admit neonates.* *2 Support for families should be sensitive to their cultural and faith needs.*
L1-196 BI Visit MP&S CNR Doc	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details *Notes:* *1 As QS L1-103 notes 1 to 3.* *2 Discharge information should be sent electronically to the patient's GP and other relevant healthcare professionals within 24 hours of discharge.* *3 More detail on discharge of children with long-term ventilation is given in the WMQRS Quality Standards for services providing Long-Term Ventilation for Children and Young People.* *4 This QS is applicable only to patients discharged directly home from L1 PCC and does not apply to patients discharged to other ward areas.*

Ref.	Quality Standard
L1-197 BI Visit MP&S CNR Doc	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services *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 L1-103 notes 1 to 3.*
L1-199 BI Visit MP&S CNR Doc	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups, electronic media and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to children's services can be identified.*
STAFFING	
L1-201 BI Visit MP&S CNR Doc	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.
L1-202 BI Visit MP&S CNR Doc	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children *Notes:* *1 'Available' means that the consultant can attend the unit if required.* *2 'Facing the Future: A Review of Paediatric Services' (RCPCH, 2015) recommends that 'all general acute paediatric rotas are made up of at least 10 WTEs all of which are EWTD compliant'.*

Ref.	Quality Standard
L1-203 BI Visit MP&S CNR Doc	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7. *Notes:* *1 'Immediately available' means able to attend within five minutes.* *2 RCPCH competence frameworks are available at: www.rcpch.ac.uk/Training/Competency-Frameworks. A competence framework and evidence of competences is required if this QS is met by use of non-medical staff.* *3 Staffing levels needed will depend on the size and layout of the unit, dependency of patients and ward round patterns. Exact staffing ratios will depend on case-mix, availability of nurse specialists and seniority of medical trainees.*
L1-205 BI Visit MP&S CNR Doc	**Medical Staff: Continuity of Care** Consultant rotas should be organised to give reasonable continuity of care. *Note: RCPCH (2015) recommends that 'all general paediatric inpatient units adopt an attending consultant system most often in the form of the 'consultant of the week' system'.*

Ref.	Quality Standard
L1-206 BI Visit MP&S CNR Doc	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS L1-208) **and** expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Care of children with acute mental health problems f. Appropriate level paediatric critical care competences: 70% of nursing staff working on the PCC Units should have appropriate level competences in paediatric critical care *Notes:* *1 Competences should be maintained through CPD.* *2 This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for assessing maintenance of competence but details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and / or where competence may not be maintained by the individual's usual clinical practice.* *3 For compliance with this QS the service should provide:* a. *A matrix of the roles within the service, competences expected and approach to maintaining competences* b. *A training and development plan showing how competences are being achieved and maintained.* *4 Training may be delivered through a variety of mechanisms, including e-learning, Hospital-Wide training and departmental training. The network education and training programme (QS N-206) will support maintenance of competences, especially in smaller units.* *5 Further detail of competences in paediatric critical care is available on The Paediatric Intensive Care Society website http://picsociety.uk/ . 'High Dependency Care for Children - Time to Move On' (RCPCH, 2014) gives more detail of expected paediatric critical care competences which should be achieved within 12 months of starting work in a PCC Unit.*

Ref.	Quality Standard
L1-207 BI Visit MP&S CNR Doc	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area c. At least one nurse per shift with appropriate level competences in paediatric critical care d. One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 critical care *Notes:* *1 'Defining Staffing Levels for Children's and Young People's Services' (RCN, 2013) and 'Safer Staffing: A Guide to Care Contact Time' (NHS England, 2014) give guidance on staffing levels and competence. Staffing levels should be related to the level of care needed by the child. This will be influenced by the patient's diagnosis and complexity and severity of illness, geographical lay-out of the unit and by the nursing skill-mix and experience.* *2 Non-registered staff with appropriate competences may be included in calculations of staffing levels per child needing critical care so long as they are working under the direct supervision of a registered nurse at all times. The ratio of registered to non-registered staff should not fall below 85:15.*
L1-208 BI Visit MP&S CNR Doc	**New Starters** Nurses and non-registered health care staff without previous paediatric critical care experience should undertake: a. A structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the PCC Unit (or in a higher level unit) b. A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months Nurses and non-registered health care staff with previous paediatric critical care experience should complete local induction and a review of competence for their expected role. *Notes:* *1 This QS links with QS L1-208 which defines the competences which should be achieved within 12 months.* *2 Additional information and support materials relating to this QS are available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*

Ref.	Quality Standard
L1-209 BI Visit MP&S CNR Doc	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. Access to a liaison health worker for children with mental health needs (7/7) c. Access to staff with competences in psychological support (at least 5/7) d. Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit) e. Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit) f. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) g. Access to dietetic service (at least 5/7) h. Access to an educator for the training, education and continuing professional development of staff *Notes:* *1 Cover for absences of all staff should be available.* *2 At least one play specialist with a Level 4 Diploma in Specialised Play for Children and Young People, a Certificate in Hospital Play Specialism, a Foundation Degree in Healthcare Play Specialism or an equivalent qualification should provide advice and guidance to staff providing support for play, mental stimulation and distraction.*
L1-298 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, as agreed by the hospital and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the hospital and local Safeguarding Board *Note: This QS is included because compliance with national safeguarding requirements is essential. Detailed consideration of safeguarding arrangements is covered by other review processes.*
L1-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*
SUPPORT SERVICES	
L1-301 BI Visit MP&S CNR Doc	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the hospital should have arrangements for review of imaging by a paediatric radiologist. *Notes:* *1 Availability within one hour applies only to services receiving critically ill and critically injured children and is not applicable to services receiving elective admissions only.* *2 Arrangements for access to MRI could include on site access or access through network arrangements with another hospital.*

Ref.	Quality Standard
FACILITIES AND EQUIPMENT	
L1-401 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: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
L1-402 BI Visit MP&S CNR Doc	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. *Notes:* *1 Drugs and equipment for in-hospital and time-critical transfers may be different. Drugs for in-hospital and time-critical transfers may be collected so long as lists of required drugs are easily visible in or near the 'grab bag'.* *2 A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/*
L1-404 BI Visit MP&S CNR Doc	**Facilities** Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care.
L1-405 BI Visit MP&S CNR Doc	**Equipment** Equipment, including disposables, should be appropriate for the usual number and age of children and the critical care interventions provided. Equipment should be checked in accordance with local policy.
L1-406 BI Visit MP&S CNR Doc	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available. *Note: 'Easily available' means within the unit or department or nearby.*
GUIDELINES AND PROTOCOLS	
L1-501 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 for full assessment exceed 15 minutes. *Note: This QS is not applicable to services which take only elective admissions or to L3 PCCUs.*

Ref.	Quality Standard
L1-502 BI Visit MP&S CNR Doc	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.
L1-503 BI Visit MP&S CNR Doc	**Resuscitation and Stabilisation** Hospital-Wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child *Note: This QS covers implementation of QS HW-501.*
L1-504 BI Visit MP&S CNR Doc	**Paediatric Advice** Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician. *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.*

Ref.	Quality Standard
L1-505 BI Visit MP&S CNR Doc	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) j. Rehabilitation after critical illness (if applicable) *Notes:* *1 Guidelines should be clear on the roles and responsibilities of all members of the multi-disciplinary team, including anaesthetic services.* *2 Guidelines should include actions to prevent / prepare for deterioration and may link with 'early warning' guidelines (QS L1-502).* *3 Where relevant, guidelines should be specific about the care of children with developmental delay, multiple disabilities or co-morbidities.* *4 Guidelines on the treatment of trauma should be based on regional trauma guidelines.* *5 'a.v' applies only to services providing care for patients with major trauma.*

Ref.	Quality Standard
L1-506 BI Visit MP&S CNR Doc	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained *Notes:* *1 Although the Specialist Paediatric Transport Service will give advice, the management of the child remains the responsibility of the referring team until the child is transferred to the Specialist Paediatric Transport Service. It is also expected that the local paediatrician and anaesthetist will remain involved with the care of the child and support the work of the Specialist Paediatric Transport Service while on-site.* *2 The Specialist Paediatric Transport Service may be a standalone service or may be part of a L3 PCCU.* *3 The Specialist Paediatric Transport Service should be contacted for children needing ECMO or burns or other specialist critical care, even if this care is not available locally.* *4 Criteria for admission to a GICU should be consistent with the agreed network criteria (QSs N-502 & 503).*
L1-507 BI Visit MP&S CNR Doc	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required. *Note: These guidelines may be combined with QS L1-506.*
L1-508 BI Visit MP&S CNR Doc	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients 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 *Notes:* *1 Most hospitals will need to transfer children, for example for opinions, investigations and treatment. Guidelines should reflect local circumstances and should cover transfer of both stable and unstable children. The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.* *2 The guidelines may be combined with QS L1-506.*

Ref.	Quality Standard
L1-509 BI Visit MP&S CNR Doc	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS L1-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS L1-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer *Notes:* *1 This QS is linked with QS HW-598e in relation to staff acting outside their area of competence.* *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 secured and there should be no loose items in the rear cabin.* *4 The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.*
L1-598 BI Visit MP&S CNR Doc	**Implementation of Hospital Guidelines** Staff should be aware of and following hospital guidelines (QS HW-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence *Note: This QS covers implementation of QS HW-598. Documentary evidence is not required for compliance with this QS. 'a' applies only to clinical areas caring for children requiring surgery.*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
L1-601 BI Visit MP&S CNR Doc	**Operational Policy** **All:** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for admission within four hours of the decision to admit g. Types of patient admitted h. Review by a senior clinician within four hours of admission i. Discussion with a consultant within four hours of admission j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff l. Discussion with a senior clinician prior to discharge *Notes:* *1 Individualised management plans may be in the form of patient passports.* *2 Notifying other relevant members of the primary health care team is desirable.* *3 Operational policies should be based on the inclusion and exclusion criteria, interventions and key performance indicators for which the service is commissioned (QS C-603). Operational policies should be clear about the care of young people aged 16 to 18 and pre-term babies discharged from neonatal units.* *4 RCPCH (2015) recommends that units work towards consultant presence 12 hours a day, seven days a week.*
GOVERNANCE	
L1-702 BI Visit MP&S CNR Doc	**Data Collection** The service should collect: a. Paediatric Intensive Care Audit Network (PICANet) data b. Paediatric Critical Care Minimum Data Set for submission to Secondary Uses Service (SUS) c. 'Quality Dashboard' data as recommended by the PCC Clinical Reference Group (CRG) *Notes:* *1 Collection by L1 Units is desirable but not yet expected.* *2 Implementation of this QS for L1 and L2 PCCUs is dependent on PICANet being contracted and funded for handling these data.*

Ref.	Quality Standard
L1-703 BI Visit MP&S CNR Doc	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS L1-500s) b. Participation in agreed national and network-wide audits c. Use of the *'Urgent and Emergency Care Clinical Audit Toolkit'* to review individual clinical consultations *Notes:* *1 The rolling programme should ensure that action plans are developed following audits and their implementation is monitored.* *2 'c' is not applicable to In-patient and L1 PCCUs which do not accept direct GP referrals.*
L1-704 BI Visit MP&S CNR Doc	**Key Performance Indicators** Key performance indicators should be reviewed regularly with hospital (or equivalent) management and with commissioners.
L1-798 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'. *Notes:* *1 These arrangements should include feedback to operational staff and should link with Hospital-Wide governance arrangements.* *2 This QS is additional to Paediatric Critical Care Network review and learning (QS N-798).* *3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.*
L1-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines and should comply with hospital document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

LEVEL 2 PAEDIATRIC CRITICAL CARE UNITS

Ref.	Quality Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
L2-101 BI Visit MP&S CNR Doc	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities. *Note: The facility should have visual and, ideally, sound separation from adult patients. More detail of recommendations for the environment in emergency care settings is given in 'Standards for Children and Young People in Emergency Care Settings' (RCPCH, 2012).*
L2-102 BI Visit MP&S CNR Doc	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child *Note: The need for privacy and confidentiality for other children and families may, in some units, mean that families cannot be present during ward rounds or handovers between clinical teams.*
L2-103 BI Visit MP&S CNR Doc	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available. *Notes:* *1 Information should be written in clear, simple language and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (DH, 2011).* *2 Information may be in paper or electronic/e-learning formats or in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.* *3 This may be general Hospital-Wide (or equivalent) information. If so, services or clinics which are specific to one condition should be clearly identified. If the information is provided only in individual patient letters then examples of these will need to be available to reviewers.*

Ref.	Quality Standard
L2-104 BI Visit MP&S CNR Doc	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Layout of the unit or ward, visiting arrangements including arrangements for children to visit, car parking advice, ward routines and location of facilities within the hospital that families may wish to use g. Relevant support groups and voluntary organisations *Note: As QS L2-103 notes 1 to 3.*
L2-105 BI Visit MP&S CNR Doc	**Facilities and Support for Families** Facilities should be available for families, including: a. Somewhere to sit away from the ward b. Quiet room for relatives c. Kitchen, toilet and washing area d. Changing area for other young children e. Midwifery and breast feeding support f. Breast feeding facilities g. Chair for parents to sit next to the child h. Accommodation on site but away from the ward/unit i. Access to psychological support *Notes:* *1 'e' is applicable only to services which admit neonates.* *2 Support for families should be sensitive to their cultural and faith needs.*
L2-196 BI Visit MP&S CNR Doc	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details *Notes:* *1 As QS L2-103 notes 1 to 3.* *2 Discharge information should be sent electronically to the patient's GP and other relevant healthcare professionals within 24 hours of discharge.* *3 More detail on discharge of children with long-term ventilation is given in the WMQRS Quality Standards for services providing Long-Term Ventilation for Children and Young People.* *4 This QS is applicable only to patients discharged directly home from L2 PCC and does not apply to patients discharged to other ward areas.*

Ref.	Quality Standard
L2-197 BI Visit MP&S CNR Doc	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services *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 L2-103 notes 1 to 3.*
L2-199 BI Visit MP&S CNR Doc	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups, electronic media and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to children's services can be identified.*
STAFFING	
L2-201 BI Visit MP&S CNR Doc	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.

Ref.	Quality Standard
L2-202 BI Visit MP&S CNR Doc	**Consultant Staffing** a. A consultant who has undertaken relevant training in paediatric critical care, who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7. If the consultant providing cover for the L2 PCC Unit is not a paediatrician, 24 hour cover by a consultant paediatrician who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites is also required b. New appointments to consultant posts in L2 PCCUs should have completed the RCPCH 'Framework of Competences for a Special Study Model in Paediatric Critical Care' (or equivalent) and should have worked for at least six months in a Level 2 and for at least six months in a Level 3 PCCU (or equivalent) c. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children *Notes:* *1 'Available' means that the consultant can attend the unit if required.* *2 'Facing the Future: A Review of Paediatric Services' (RCPCH, 2015) recommends that 'all general acute paediatric rotas are made up of at least 10 WTEs all of which are EWTD compliant'.* *3 This is a developmental QS. Level 2 Units should meet the Level 1 Standard immediately and should reach the Level 2 Standard by 2018. In the early years of implementation of this QS Level 2 PCCUs may not have been formally designated and equivalent experience should be accepted. Appendix 7 of 'High Dependency Care for Children - Time to Move On' (RCPCH, 2014) gives further detail of the expected enhanced paediatric critical care competences.*

Ref.	Quality Standard
L2-203 BI Visit MP&S CNR Doc	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant At least one clinician should be immediately available who is either: a. A paediatric trainee with at least Level 2 RCPCH (or equivalent) competences. Doctors in training should normally be ST6 or above, OR b. A paediatric trainee (at any RCPCH level) who has completed at least 6 months working in a Level 3 Unit, OR c. An anaesthetic specialty trainee, OR d. An advanced nurse practitioner or hospital / Specialty Doctor with equivalent competences, OR e. A consultant (QS L2-202) Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7. *Notes:* *1 'Immediately available' means able to attend within five minutes.* *2 RCPCH competence frameworks are available at: www.rcpch.ac.uk/Training/Competency-Frameworks. A competence framework and evidence of competences is required if this QS is met by use of non-medical staff.* *3 Staffing levels needed will depend on the size and layout of the unit, dependency of patients and ward round patterns. Exact staffing ratios will depend on case-mix, availability of nurse specialists and seniority of medical trainees.* *4 This is a developmental QS for Level 2 Units. The Level 1 Standard should be met immediately and the Level 2 Standard should be reached by 2018.*
L2-205 BI Visit MP&S CNR Doc	**Medical Staff: Continuity of Care** Consultant rotas should be organised to give reasonable continuity of care. *Note: RCPCH (2015) recommends that 'all general paediatric inpatient units adopt an attending consultant system most often in the form of the 'consultant of the week' system'.*

Ref.	Quality Standard
L2-206 BI Visit MP&S CNR Doc	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS L2-208) **and** expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Appropriate level paediatric critical care competences: 70% of nursing staff working on the PCC Units should have appropriate level competences in paediatric critical care f. Care of children with tracheostomies g. Care of children needing acute and chronic non-invasive ventilation, and tracheostomy ventilation *Notes:* *1 Competences should be maintained through CPD.* *2 This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for assessing maintenance of competence but details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and / or where competence may not be maintained by the individual's usual clinical practice.* *3 For compliance with this QS the service should provide:* a. *A matrix of the roles within the service, competences expected and approach to maintaining competences* b. *A training and development plan showing how competences are being achieved and maintained.* *4 Training may be delivered through a variety of mechanisms, including e-learning, Hospital-Wide training and departmental training. The network education and training programme (QS N-206) will support maintenance of competences, especially in smaller units.* *5 Further detail of competences in paediatric critical care is available on The Paediatric Intensive Care Society website http://picsociety.uk/ . 'High Dependency Care for Children - Time to Move On' (RCPCH, 2014) gives more detail of expected paediatric critical care competences which should be achieved within 12 months of starting work in a PCC Unit.* *6 Staff working in specialty-specific Level 2 Units should achieve all the competences for Level 2 paediatric critical care as well as appropriate specialty-specific competences.* *7 Competences in paediatric critical care should be assessed through a validated/accredited education and training programme.*

Ref.	Quality Standard
L2-207 BI Visit MP&S CNR Doc	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area c. At least one nurse per shift with appropriate level competences in paediatric critical care d. One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 or Level 2 critical care e. At least one nurse per shift with competences in care of children with tracheostomies and those requiring non-invasive or tracheostomy ventilation *Notes:* *1 'Defining Staffing Levels for Children's and Young People's Services' (RCN, 2013) and 'Safer Staffing: A Guide to Care Contact Time' (NHS England, 2014) give guidance on staffing levels and competence. Staffing levels should be related to the level of care needed by the child. This will be influenced by the patient's diagnosis and complexity and severity of illness, geographical lay-out of the unit and by the nursing skill-mix and experience.* *2 All PCC: Non-registered staff with appropriate competences may be included in calculations of staffing levels per child needing critical care so long as they are working under the direct supervision of a registered nurse at all times. The ratio of registered to non-registered staff should not fall below 85:15.* *3 Staff required to meet 'minimum staffing levels' should have achieved all appropriate level competences in paediatric critical care as assessed through a validated/accredited education and training programme. Further details are available on The Paediatric Intensive Care Society website: http://picsociety.uk/ .* *4 Healthcare staff caring for children with tracheostomies may include non-registered health care staff who normally care for the child in the community. Parents who have received appropriate training may also contribute to this care.*
L2-208 BI Visit MP&S CNR Doc	**New Starters** Nurses and non-registered health care staff without previous paediatric critical care experience should undertake: a. A structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the PCC Unit (or in a higher level unit) b. A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months Nurses and non-registered health care staff with previous paediatric critical care experience should complete local induction and a review of competence for their expected role. *Notes:* *1 This QS links with QS L2-208 which defines the competences which should be achieved within 12 months.* *2 Additional information and support materials relating to this QS are available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*

Ref.	Quality Standard
L2-209 BI Visit MP&S CNR Doc	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit) c. Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit) d. Access to an educator for the training, education and continuing professional development of staff e. A discharge coordinator responsible for managing the discharge of children with complex care needs f. An educator for the training, education and continuing professional development of staff g. Pharmacist with competences in paediatric critical care (with time allocated at least 5/7 for work on the unit) h. Physiotherapist with competences in paediatric critical care (with time allocated at least 5/7 for work on the unit) i. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) j. Dietetic staff (with time allocated 5/7 for work on the unit) k. Staff with competences in psychological support with time allocated in their job plan for work with: I. families II. staff *Notes:* *1 Cover for absences of all staff should be available.* *2 At least one play specialist with a Level 4 Diploma in Specialised Play for Children and Young People, a Certificate in Hospital Play Specialism, a Foundation Degree in Healthcare Play Specialism or an equivalent qualification should provide advice and guidance to staff providing support for play, mental stimulation and distraction.* *3 The discharge coordinator may have other responsibilities so long as sufficient time is available for managing discharges from paediatric critical care.* *4 Pharmacy, physiotherapy, dietetic, psychological support and health care scientist staff: The amount of time should be appropriate for the usual number and case mix of patients.*
L2-298 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, as agreed by the hospital and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the hospital and local Safeguarding Board *Note: This QS is included because compliance with national safeguarding requirements is essential. Detailed consideration of safeguarding arrangements is covered by other review processes.*
L2-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*

Ref.	Quality Standard
SUPPORT SERVICES	
L2-301 BI Visit MP&S CNR Doc	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the hospital should have arrangements for review of imaging by a paediatric radiologist. *Notes:* *1 Availability within one hour applies only to services receiving critically ill and critically injured children and is not applicable to services receiving elective admissions only.* *2 Arrangements for access to MRI could include on site access or access through network arrangements with another hospital.*
L2-302 BI Visit MP&S CNR Doc	**Co-located Services** L2 PCC Units should be co-located with ENT services for the support of children with tracheostomies. *Note: More detail of co-location, 'integrated clinical service' and expectations of related services is given in 'Commissioning Safe and Sustainable Specialised Paediatric Services', (DH, 2008).*
FACILITIES AND EQUIPMENT	
L2-401 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: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
L2-402 BI Visit MP&S CNR Doc	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. *Notes:* *1 Drugs and equipment for in-hospital and time-critical transfers may be different. Drugs for in-hospital and time-critical transfers may be collected so long as lists of required drugs are easily visible in or near the 'grab bag'.* *2 A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
L2-404 BI Visit MP&S CNR Doc	**Facilities** Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care. *Note: Latest Health Building notes (HBN) guidance should be taken into account in the design of these facilities.*

Ref.	Quality Standard
L2-405 BI Visit MP&S CNR Doc	**Equipment** Equipment, including disposables, should be appropriate for the usual number and age of children and the critical care interventions provided. Equipment should be checked in accordance with local policy. As a minimum, each bed space should have the capacity for: a. ECG, respiration, pulse-oximetry and non-invasive blood pressure monitoring b. Transducing two pressure traces c. Temperature monitoring at two sites These monitors should be available in a modular unit capable of integration with monitors used in the Emergency Department, theatres and portable monitoring systems.
L2-406 BI Visit MP&S CNR Doc	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available. *Note: 'Easily available' means within the unit or department or nearby.*
GUIDELINES AND PROTOCOLS	
L2-501 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 for full assessment exceed 15 minutes. *Note: This QS is not applicable to services which take only elective admissions or to L3 PCCUs.*
L2-502 BI Visit MP&S CNR Doc	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.
L2-503 BI Visit MP&S CNR Doc	**Resuscitation and Stabilisation** Hospital-Wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child *Note: This QS covers implementation of QS HW-501.*
L2-504 BI Visit MP&S CNR Doc	**Paediatric Advice** Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician. *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.*

Ref.	Quality Standard
L2-505 BI Visit MP&S CNR Doc	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) j. Rehabilitation after critical illness (if applicable) k. Acute non-invasive ventilation (CPAP and BiPAP) l. Tracheostomy care, including management of a tracheostomy emergency m. Care of children on long-term ventilation (tracheostomy and mask) *Notes:* *1 Guidelines should be clear on the roles and responsibilities of all members of the multi-disciplinary team, including anaesthetic services.* *2 Guidelines should include actions to prevent / prepare for deterioration and may link with 'early warning' guidelines (QS L2-502).* *3 Where relevant, guidelines should be specific about the care of children with developmental delay, multiple disabilities or co-morbidities.* *4 Guidelines on the treatment of trauma should be based on regional trauma guidelines.* *5 'a.v' applies only to services providing care for patients with major trauma.* *6 WMQRS Quality Standards for the Care of Children and Young People needing Long-Term Ventilation give more detail of the expected standards of care.*

Ref.	Quality Standard
L2-506 BI Visit MP&S CNR Doc	**PCC Transfer Guidelines** Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least: a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained. *Notes:* *1 Although the Specialist Paediatric Transport Service will give advice, the management of the child remains the responsibility of the referring team until the child is transferred to the Specialist Paediatric Transport Service. It is also expected that the local paediatrician and anaesthetist will remain involved with the care of the child and support the work of the Specialist Paediatric Transport Service while on-site.* *2 The Specialist Paediatric Transport Service may be a standalone service or may be part of a L3 PCCU.* *3 The Specialist Paediatric Transport Service should be contacted for children needing ECMO or burns or other specialist critical care, even if this care is not available locally.* *4 Criteria for admission to a GICU should be consistent with the agreed network criteria (QSs N-502 & 503).*
L2-507 BI Visit MP&S CNR Doc	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required. *Notes:* *1 These guidelines may be combined with QS L2-506.* *2 In hospitals with both L2 and L3 PCCUs, the guidelines should cover transfer between L2 and L3 Units.*
L2-508 BI Visit MP&S CNR Doc	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients 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 *Notes:* *1 Most hospitals will need to transfer children, for example for opinions, investigations and treatment. Guidelines should reflect local circumstances and should cover transfer of both stable and unstable children. The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.* *2 The guidelines may be combined with QS L2-506.*

Ref.	Quality Standard
L2-509 BI Visit MP&S CNR Doc	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS L2-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS L2-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer *Notes:* *1 This QS is linked with QS HW-598e in relation to staff acting outside their area of competence.* *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 secured and there should be no loose items in the rear cabin.* *4 The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.*
L2-598 BI Visit MP&S CNR Doc	**Implementation of Hospital Guidelines** Staff should be aware of and following hospital guidelines (QS HW-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence *Note: This QS covers implementation of QS HW-598. Documentary evidence is not required for compliance with this QS. 'a' applies only to clinical areas caring for children requiring surgery.*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
L2-601 BI Visit MP&S CNR Doc	**Operational Policy** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Arrangements for consultant presence during 'times of peak activity' (7/7) e. Servicing and maintaining equipment, including 24 hour call out where appropriate f. Arrangements for admission within four hours of the decision to admit g. Types of patient admitted h. Review by a senior clinician within four hours of admission i. Discussion with a consultant within four hours of admission j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff l. Discussion with a senior clinician prior to discharge m. Arrangements for discharge within four hours of the decision to discharge n. Arrangements for critical care 'outreach' to other wards within the hospital o. Discharge of children with tracheostomies: i. Suitability for discharge ii. Staffing and monitoring facilities that should be in place prior to discharge iii. Process for planning and agreement of discharge p. Discharge of children on long-term ventilation q. Agreed contribution to the network-wide training and CPD programme (QS N-206) *Notes:* *1 Individualised management plans may be in the form of patient passports.* *2 Notifying other relevant members of the primary health care team is desirable.* *3 Operational policies should be based on the inclusion and exclusion criteria, interventions and key performance indicators for which the service is commissioned (QS C-603). Operational policies should be clear about the care of young people aged 16 to 18 and pre-term babies discharged from neonatal units.* *4 RCPCH (2015) recommends that units work towards consultant presence 12 hours a day, seven days a week.* *5 Details of the expected guidelines for the discharge of children on long-term ventilation are given in Quality Standards for Services Providing Long-Term Ventilation for Children and Young People.* *7 Guidelines for admission to PCC Units should cover admissions from the unit's host hospital as well as from referring hospitals.* *8 The NHS Standard Contract for Paediatric Critical Care (Schedule 2) gives additional detail on criteria for admission to paediatric critical care.* *9 The operational policy should ensure discharges do not normally occur between 22.00 and 06.59. This is monitored in QS L2-702.*

Ref.	Quality Standard
GOVERNANCE	
L2-702 BI Visit MP&S CNR Doc	**Data Collection** The service should collect and submit: a. Paediatric Intensive Care Audit Network (PICANet) data for submission to PICANet as soon as possible and no later than three months after discharge from the PCC Unit b. Paediatric Critical Care Minimum Data Set for submission to PICANet and SUS c. 'Quality Dashboard' data as recommended by the PCC CRG *Notes:* *1 Implementation of this QS for L1 and L2 PCCUs is dependent on PICANet being contracted and funded for handling these data.* *2 The PICANet Annual Report provides the documentation required for showing compliance with 'a'.*
L2-703 BI Visit MP&S CNR Doc	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS L2-500s) b. Participation in agreed national and network-wide audits c. Discharges between 22.00 and 06.59 d. Number of operations cancelled on the day of surgery due to the lack of a paediatric critical care bed *Note: The rolling programme should ensure that action plans are developed following audits and their implementation is monitored.*
L2-704 BI Visit MP&S CNR Doc	**Key Performance Indicators** Key performance indicators should be reviewed regularly with hospital (or equivalent) management and with commissioners, including 'Quality Dashboard' data as recommended by the PCC CRG.
L2-798 BI Visit MP&S CNR Doc	**Review and Learning** The service should have appropriate multi-disciplinary arrangements for: a. Review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses' b. Review and dissemination of published scientific evidence relating to paediatric critical care *Notes:* *1 These arrangements should include feedback to operational staff and should link with Hospital-Wide governance arrangements.* *2 This QS is additional to paediatric critical care network review and learning (QS N-798).* *3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.*
L2-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines and should comply with hospital document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

LEVEL 3 PAEDIATRIC CRITICAL CARE UNITS

Ref.	Quality Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
L3-101 BI Visit MP&S CNR Doc	**Child-friendly Environment** Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities. *Note: The facility should have visual and, ideally, sound separation from adult patients. More detail of recommendations for the environment in emergency care settings is given in 'Standards for Children and Young People in Emergency Care Settings' (RCPCH, 2012).*
L3-102 BI Visit MP&S CNR Doc	**Parental Access and Involvement** Parents should: a. Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families b. Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly c. Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child *Note: The need for privacy and confidentiality for other children and families may, in some units, mean that families cannot be present during ward rounds or handovers between clinical teams.*
L3-103 BI Visit MP&S CNR Doc	**Information for Children** Children should be offered age-appropriate information, encouragement and support to enable them to share in decisions about their care. Written information about common conditions should be available. *Notes:* *1 Information should be written in clear, simple language and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (DH, 2011).* *2 Information may be in paper or electronic/e-learning formats or in the form of a website or other social media. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.* *3 This may be general Hospital-Wide (or equivalent) information. If so, services or clinics which are specific to one condition should be clearly identified. If the information is provided only in individual patient letters then examples of these will need to be available to reviewers.*

Ref.	Quality Standard
L3-104 BI Visit MP&S CNR Doc	**Information for Families** Information for families should be available covering, at least: a. The child's condition b. How parents can take part in decisions about their child's care c. Participation in the delivery of care and presence during interventions d. Support available including access to psychological and financial support e. How to get a drink and food f. Layout of the unit or ward, visiting arrangements including arrangements for children to visit, car parking advice, ward routines and location of facilities within the hospital that families may wish to use g. Relevant support groups and voluntary organisations *Note: As QS L3-103 notes 1 to 3.*
L3-105 BI Visit MP&S CNR Doc	**Facilities and Support for Families** Facilities should be available for families, including: a. Somewhere to sit away from the ward b. Quiet room for relatives c. Kitchen, toilet and washing area d. Changing area for other young children e. Midwifery and breast feeding support f. Breast feeding facilities g. Chair for parents to sit next to the child h. Accommodation on site but away from the ward/unit i. Access to psychological support *Notes:* *1 'e' is applicable only to services which admit neonates.* *2 Support for families should be sensitive to their cultural and faith needs.*
L3-196 BI Visit MP&S CNR Doc	**Discharge Information** On discharge home, children and families should be offered written information about: a. Care after discharge b. Early warning signs of problems and what to do if these occur c. Who to contact for advice and their contact details *Notes:* *1 As QS L3-103 notes 1 to 3.* *2 Discharge information should be sent electronically to the patient's GP and other relevant healthcare professionals within 24 hours of discharge.* *3 More detail on discharge of children with long-term ventilation is given in the WMQRS Quality Standards for services providing Long-Term Ventilation for Children and Young People.* *4 This QS is applicable only to patients discharged directly home from L3 PCC and does not apply to patients discharged to other ward areas.*

Ref.	Quality Standard
L3-197 BI Visit MP&S CNR Doc	**Additional Support for Families** Families should have access to the following support and information about these services should be available: a. Interfaith and spiritual support b. Social workers c. Interpreters d. Bereavement support e. Patient Advice and Advocacy Services *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 L3-103 notes 1 to 3.*
L3-199 BI Visit MP&S CNR Doc	**Involving Children and Families** The service should have: a. Mechanisms for receiving feedback from children and families about the treatment and care they receive b. Mechanisms for involving children and families in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of children and families *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups, electronic media and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to children's services can be identified.*
STAFFING	
L3-201 BI Visit MP&S CNR Doc	**Lead Consultant and Lead Nurse** A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.

Ref.	Quality Standard
L3-202 BI Visit MP&S CNR Doc	**Consultant Staffing** a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7 b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children c. A consultant who has undertaken relevant training in paediatric intensive care medicine as described by the Paediatric Intensive Care Medicine Specialty Advisory Committee (PICM ISAC) or an equivalent national organisation, including at least two years of L3 PCCU training and a period of anaesthesia training (paediatric trainees) or paediatric training (anaesthesia trainees), should be available 24/7. When on duty for the L3 PCC Unit consultants should not have clinical responsibilities elsewhere. The following consultant staffing should be available: i. **'Normal working hours':** At least one consultant for up to 12 beds for children needing Level 3 critical care and for each subsequent 12 beds ii. **Outside 'normal working hours':** At least one consultant for up to 20 critical care beds and for each subsequent 20 beds. All consultants should have regular day-time commitments on the unit *Notes:* *1 'Available' means that the consultant can attend the unit if required.* *2 An increasing amount of consultants' time should be allocated to working on the unit as the number of PICU beds increases within each 'cell' of up to 12 beds. For example, units of 16 to 24 beds should normally have two consultants working on the unit during normal working hours. Patient case mix and complexity / acuity will also need to be taken into account and units that admit more patients needing L2 PCC will not require the same staffing level.* *3 The training requirements do not apply to consultants appointed prior to 2010 who have achieved equivalent competences through experience.* *4 The definition of 'normal working hours' should take into account times of peak activity.*

Ref.	Quality Standard
L3-203 BI Visit MP&S CNR Doc	**'Middle Grade' Clinician** A 'middle grade' clinician with the following competences should be immediately available at all times: a. Advanced paediatric resuscitation and life support b. Assessment of the ill child and recognition of serious illness and injury c. Initiation of appropriate immediate treatment d. Prescribing and administering resuscitation and other appropriate drugs e. Provision of appropriate pain management f. Effective communication with children and their families g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant At least one clinician should be immediately available who is either: 1. A paediatric trainee with at least Level 2 RCPCH (or equivalent) competences. Doctors in training should normally be ST6 or above, OR 2. A paediatric trainee (at any RCPCH level) who has completed at least 6 months working in a Level 3 Unit, OR 3. An anaesthetic specialty trainee, OR 4. An advanced nurse practitioner or Hospital / Specialty Doctor with equivalent competences, OR 5. A consultant (QS L3-202) Staffing levels should be: i. During normal working hours: one clinician for every five beds ii. Outside normal working hours: one clinician for every eight beds *Notes:* *1 'Immediately available' means able to attend within five minutes.* *2 RCPCH competence frameworks are available at: www.rcpch.ac.uk/Training/Competency-Frameworks. A competence framework and evidence of competences is required if this QS is met by use of non-medical staff.* *3 Staffing levels needed will depend on the size and layout of the unit, dependency of patients and ward round patterns. Exact staffing ratios will depend on case-mix, availability of nurse specialists and seniority of medical trainees.* *4 This clinician should not be covering the Specialist Paediatric Transport Service. Specialist Paediatric Transport Service staff may support L3 PCCU if not required for an emergency transfer so long as they are immediately available to the Specialist Paediatric Transport Service when required. The clinician may have responsibility for critical care 'outreach' to other wards within the same hospital site.* *5 The definition of 'normal working hours' should take into account times of peak activity.*
L3-204 BI Visit MP&S CNR Doc	**Consultants with Lead Responsibility** The lead consultant should be supported by consultants with lead responsibility for the following areas: a. Clinical governance b. Organ donation c. Research d. Medical education and training e. Care of children needing long-term respiratory support *Note: A consultant may have responsibility for more than one area. These roles should be recognised in consultants' job plans.*

Ref.	Quality Standard
L3-205 BI Visit MP&S CNR Doc	**Medical Staff: Continuity of Care** Consultant rotas should be organised to give reasonable continuity of care. *Note: RCPCH (2015) recommends that 'all general paediatric inpatient units adopt an attending consultant system most often in the form of the 'consultant of the week' system'.*
L3-206 BI Visit MP&S CNR Doc	**Competence Framework and Training Plan – Staff Providing Bedside Care** A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including: a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS L3-208) **and** expected input to the paediatric resuscitation team (QS HW-204) b. Care and rehabilitation of children with trauma (if applicable) c. Care of children needing surgery (if applicable) d. Use of equipment as expected for their role e. Appropriate level paediatric critical care competences: 70% of nursing staff working on the PCC Units should have appropriate level competences in paediatric critical care f. Care of children with tracheostomies g. Care of children needing acute and chronic non-invasive ventilation, and tracheostomy ventilation h. Care of the intubated child, invasive mechanical ventilation, blood gas interpretation, monitoring and management of analgesia and sedation, haemodynamic monitoring and inotropic support, and care of arterial and central venous lines *Notes:* *1 Competences should be maintained through CPD.* *2 This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for assessing maintenance of competence but details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and / or where competence may not be maintained by the individual's usual clinical practice.* *3 For compliance with this QS the service should provide:* a. *A matrix of the roles within the service, competences expected and approach to maintaining competences* b. *A training and development plan showing how competences are being achieved and maintained.* *4 Training may be delivered through a variety of mechanisms, including e-learning, Hospital-Wide training and departmental training. The network education and training programme (QS N-206) will support maintenance of competences, especially in smaller units.* *5 Further detail of competences in paediatric critical care is available on The Paediatric Intensive Care Society website http://picsociety.uk/ . 'High Dependency Care for Children - Time to Move On' (RCPCH, 2014) gives more detail of expected paediatric critical care competences which should be achieved within 12 months of starting work in a PCC Unit.* *6 Competences in paediatric critical care should be assessed through a validated/accredited education and training programme.*

Ref.	Quality Standard
L3-207 BI Visit MP&S CNR Doc	**Staffing Levels: Bedside Care** Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved: a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift b. At least two registered children's nurses on duty at all times in each area c. At least one nurse per shift with appropriate level competences in paediatric critical care d. One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 or Level 2 critical care e. At least one nurse per shift with competences in care of children with tracheostomies and those requiring non-invasive or tracheostomy ventilation f. One nurse with appropriate level competences in paediatric critical care for every child needing Level 3 critical care g. Supernumerary shift leader for every eight to ten beds for children needing Level 3 care *Notes:* *1 'Defining Staffing Levels for Children's and Young People's Services' (RCN, 2013) and 'Safer Staffing: A Guide to Care Contact Time' (NHS England, 2014) give guidance on staffing levels and competence. Staffing levels should be related to the level of care needed by the child. This will be influenced by the patient's diagnosis and complexity and severity of illness, geographical lay-out of the unit and by the nursing skill-mix and experience.* *2 ED: Draft NICE guidance on nurse staffing in A&E departments is that "where the level of service provided does not warrant this [one registered children's nurse on each shift], at least 1 A&E nurse on each shift with education, training and competency in children's nursing.".* *3 Non-registered staff with appropriate competences may be included in calculations of staffing levels per child needing critical care so long as they are working under the direct supervision of a registered nurse at all times. The ratio of registered to non-registered staff should not fall below 85:15.* *4 Staff required to meet 'minimum staffing levels' should have achieved all appropriate level competences in paediatric critical care as assessed through a validated/accredited education and training programme. Further details are available on The Paediatric Intensive Care Society website: http://picsociety.uk/ .* *5 Healthcare staff caring for children with tracheostomies may include non-registered health care staff who normally care for the child in the community. Parents who have received appropriate training may also contribute to this care.* *6 An establishment of at least 7.01 nurses and non-registered health care staff per bed for children needing Level 3 care will be required to achieve this QS (PICS, 2010). This includes an allowance of 25% non-patient contact time for annual, maternity, sickness, special and study leave. Further details are available on The Paediatric Intensive Care Society website: http://picsociety.uk/ .*

Ref.	Quality Standard
L3-208 BI Visit MP&S CNR Doc	**New Starters** Nurses and non-registered health care staff without previous paediatric critical care experience should undertake: a. A structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the PCC Unit (or in a higher level unit) b. A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months Nurses and non-registered health care staff with previous paediatric critical care experience should complete local induction and a review of competence for their expected role. *Notes:* *1 This QS links with QS L3-208 which defines the competences which should be achieved within 12 months.* *2 Additional information and support materials relating to this QS are available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
L3-209 BI Visit MP&S CNR Doc	**Other Staffing** The following staff should be available: a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7) b. A discharge coordinator responsible for managing the discharge of children with complex care needs c. An educator for the training, education and continuing professional development of staff d. Pharmacist with competences in paediatric critical care (with time allocated at least 5/7 for work on the unit) e. Physiotherapist with competences in paediatric critical care (with time allocated at least 5/7 for work on the unit) f. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7) g. Dietetic staff (with time allocated 5/7 for work on the unit) h. Staff with competences in psychological support with time allocated in their job plan for work with: I. families II. staff i. At least one whole time equivalent (WTE) educator for each 50 nurses, non-registered health care staff and allied health professionals within the L3 PCCU j. An educator for families of children with complex and / or equipment needs who are going home k. Health care scientist or other technical support arrangements for the management of equipment l. Operating Department Practitioners (or equivalent staff) with competences in assisting with advanced airway interventions (24/7) *Notes:* *1 Cover for absences of all staff should be available.* *2 At least one play specialist with a Level 4 Diploma in Specialised Play for Children and Young People, a Certificate in Hospital Play Specialism, a Foundation Degree in Healthcare Play Specialism or an equivalent qualification should provide advice and guidance to staff providing support for play, mental stimulation and distraction.* *3 The discharge coordinator may have other responsibilities so long as sufficient time is available for managing discharges from paediatric critical care.* *4 Pharmacy, physiotherapy, dietetic, psychological support and health care scientist staff: The amount of time should be appropriate for the usual number and case mix of patients.*

Ref.	Quality Standard
L3-298 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, as agreed by the hospital and local Safeguarding Board b. Be aware of who to contact if they have concerns about safeguarding issues c. Work in accordance with latest national guidance on safeguarding children and the safeguarding policy of the hospital and local Safeguarding Board *Note: This QS is included because compliance with national safeguarding requirements is essential. Detailed consideration of safeguarding arrangements is covered by other review processes.*
L3-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*
SUPPORT SERVICES	
L3-301 BI Visit MP&S CNR Doc	**Imaging Services** 24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the hospital should have arrangements for review of imaging by a paediatric radiologist. *Notes:* *1 Availability within one hour applies only to services receiving critically ill and critically injured children and is not applicable to services receiving elective admissions only.* *2 Arrangements for access to MRI could include on site access or access through network arrangements with another hospital.*
L3-302 BI Visit MP&S CNR Doc	**Co-located Services** L3 PCC Units should be co-located with the following services: a. ENT (Airway) b. Specialised paediatric surgery c. Specialised paediatric anaesthesia L3 PCC Units should be co-located or work as an 'integrated clinical service' with the following paediatric services: d. Clinical haematology e. Respiratory medicine f. Cardiology g. Congenital cardiac surgery h. Neuro-surgery *Note: More detail of co-location, 'integrated clinical service' and expectations of related services is given in 'Commissioning Safe and Sustainable Specialised Paediatric Services', (DH, 2008).*

Ref.	Quality Standard
FACILITIES AND EQUIPMENT	
L3-401 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: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
L3-402 BI Visit MP&S CNR Doc	**'Grab Bag'** Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy. *Notes:* *1 Drugs and equipment for in-hospital and time-critical transfers may be different. Drugs for in-hospital and time-critical transfers may be collected so long as lists of required drugs are easily visible in or near the 'grab bag'.* *2 A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
L3-404 BI Visit MP&S CNR Doc	**Facilities** Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care. *Note: Latest HBN guidance should be taken into account in the design of these facilities.*
L3-405 BI Visit MP&S CNR Doc	**Equipment** Equipment, including disposables, should be appropriate for the usual number and age of children and the critical care interventions provided. Equipment should be checked in accordance with local policy. As a minimum, each bed space should have the capacity for: a. ECG, respiration, pulse-oximetry and non-invasive blood pressure monitoring b. Transducing three pressure traces c. Temperature monitoring at two sites d. Capnography These monitors should be available in a modular unit capable of integration with monitors used in the Emergency Department, theatres and portable monitoring systems.
L3-406 BI Visit MP&S CNR Doc	**'Point of Care' Testing** 'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available. *Note: 'Easily available' means within the unit or department or nearby.*

Ref.	Quality Standard
GUIDELINES AND PROTOCOLS	
L3-502 BI Visit MP&S CNR Doc	**Paediatric Early Warning System** A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.
L3-503 BI Visit MP&S CNR Doc	**Resuscitation and Stabilisation** Hospital-Wide protocols for resuscitation and stabilisation should be in use, including: a. Alerting the paediatric resuscitation team b. Arrangements for accessing support for difficult airway management c. Stabilisation and ongoing care d. Care of parents during the resuscitation of a child *Note: This QS covers implementation of QS HW-501.*
L3-505 BI Visit MP&S CNR Doc	**Clinical Guidelines** The following clinical guidelines should be in use: a. Treatment of all major conditions, including: i. acute respiratory failure (including bronchiolitis and asthma) ii. sepsis (including septic shock and meningococcal infection) iii. management of diabetic ketoacidosis iv. seizures and status epilepticus v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) vi. burns and scalds vii. cardiac arrhythmia viii. upper airway obstruction b. Management of acutely distressed children, including use of restraint c. Drug administration and medicines management d. Pain management e. Procedural sedation and analgesia f. Infection control and antibiotic prescribing g. Tissue viability, including extravasation h. Nasal high flow therapy (if used) i. Management of children undergoing surgery (if applicable) j. Rehabilitation after critical illness (if applicable) k. Acute non-invasive ventilation (CPAP and BiPAP) l. Tracheostomy care, including management of a tracheostomy emergency m. Care of children on long-term ventilation (tracheostomy and mask) n. Haemofiltration and / or haemodiafiltration o. HFOV p. ECMO (if available) q. Referral and transfer of patients to services which are not available on site r. Brain stem death and organ and tissue donation s. Palliative care t. End of life care, including withdrawal of treatment u. Bereavement

Ref.	Quality Standard
	Notes: *1 Guidelines should be clear on the roles and responsibilities of all members of the multi-disciplinary team, including anaesthetic services.* *2 Guidelines should include actions to prevent / prepare for deterioration and may link with 'early warning' guidelines (QS L3-502).* *3 Where relevant, guidelines should be specific about the care of children with developmental delay, multiple disabilities or co-morbidities.* *4 Guidelines on the treatment of trauma should be based on regional trauma guidelines.* *5 'a.v' applies only to services providing care for patients with major trauma.* *6 WMQRS Quality Standards for the Care of Children and Young People needing Long-Term Ventilation give more detail of the expected standards of care.* *7 Further guidance on the care of children with tracheostomies is given in 'Commissioning Safe and Sustainable Specialised Paediatric Services', (DH, 2008).* *8 'p' should cover access to ECMO, transplantation and other services for which 'integrated care', 'next working day' or 'access as required' is expected IF these are not available on site. Further details of these services is given in 'Commissioning Safe and Sustainable Specialised Paediatric Services', (DH, 2008).* *9 Guidelines on palliative care, organ and tissue donation, end of life care and bereavement should be specific to the needs of children and their families. RCPCH guidance 'Making decisions to limit treatment in life-threatening and life-limiting conditions in children: a framework for practice' (2015) may be helpful in developing local guidelines.*
L3-507 BI Visit MP&S CNR Doc	**In-hospital Transfer Guidelines** Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required. *Notes:* *1 These guidelines may be combined with QS L3-506.* *2 In hospitals with both L2 and L3 PCCUs, the guidelines should cover transfer between L2 and L3 Units.*
L3-508 BI Visit MP&S CNR Doc	**Inter-hospital Transfer Guidelines** Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least: a. Types of patients 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 *Notes:* *1 Most hospitals will need to transfer children, for example for opinions, investigations and treatment. Guidelines should reflect local circumstances and should cover transfer of both stable and unstable children. The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.* *2 The guidelines may be combined with QS L3-506.*

Ref.	Quality Standard
L3-509 BI Visit MP&S CNR Doc	**Time-Critical Transfer Guidelines** Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include: a. Securing advice from the Specialist Paediatric Transport Service (QS L3-506) b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management c. Indemnity for escort team d. Availability of drugs and equipment, checked in accordance with local policy (QS L3-402) e. Arrangements for emergency transport with a local ambulance service and the air ambulance f. Arrangements for ensuring restraint of children, equipment and staff during transfer *Notes:* *1 This QS is linked with QS HW-598e in relation to staff acting outside their area of competence.* *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 secured and there should be no loose items in the rear cabin.* *4 The advice of the Paediatric Critical Care Operational Delivery Network and the Specialist Paediatric Transport Service for the local population may be helpful in developing local guidelines.* *5 This Qs is applicable to L3 PCC Units in hospitals which host a SPTS as time-critical transfers to other specialist services may be required.*
L3-598 BI Visit MP&S CNR Doc	**Implementation of Hospital Guidelines** Staff should be aware of and following hospital guidelines (QS HW-598) for: a. Surgery and anaesthesia for children b. Consent c. Organ and tissue donation d. Palliative care e. Bereavement f. Staff acting outside their area of competence *Note: This QS covers implementation of QS HW-598. Documentary evidence is not required for compliance with this QS. 'a' applies only to clinical areas caring for children requiring surgery.*

Ref.	Quality Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
L3-601 BI Visit MP&S CNR Doc	**Operational Policy** The service should have an operational policy covering at least: a. Individualised management plans are accessible for children who have priority access to the service (where applicable) b. Informing the child's GP of their attendance / admission c. Level of staff authorised to discharge children d. Servicing and maintaining equipment, including 24 hour call out where appropriate e. Arrangements for admission within four hours of the decision to admit f. Types of patient admitted g. Review by a senior clinician within four hours of admission h. Discussion with a consultant within four hours of admission i. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours j. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff k. Discussion with a senior clinician prior to discharge l. Arrangements for discharge within four hours of the decision to discharge m. Arrangements for critical care 'outreach' to other wards within the hospital n. Discharge of children with tracheostomies: i. Suitability for discharge ii. Staffing and monitoring facilities that should be in place prior to discharge iii. Process for planning and agreement of discharge o. Discharge of children on long-term ventilation p. Agreed contribution to the network-wide training and CPD programme (QS N-206) *Notes:* *1 Individualised management plans may be in the form of patient passports.* *2 Notifying other relevant members of the primary health care team is desirable.* *3 Operational policies should be based on the inclusion and exclusion criteria, interventions and key performance indicators for which the service is commissioned (QS C-603). Operational policies should be clear about the care of young people aged 16 to 18 and pre-term babies discharged from neonatal units.* *4 RCPCH (2015) recommends that units work towards consultant presence 12 hours a day, seven days a week.* *5 Details of the expected guidelines for the discharge of children on long-term ventilation are given in Quality Standards for Services Providing Long-Term Ventilation for Children and Young People.* *7 Guidelines for admission to PCC Units should cover admissions from the unit's host hospital as well as from referring hospitals.* *8 The NHS Standard Contract for Paediatric Critical Care (Schedule 2) gives additional detail on criteria for admission to paediatric critical care.* *9 The operational policy should ensure discharges do not normally occur between 22.00 and 06.59. This is monitored in QS L3-702.*

Ref.	Quality Standard
GOVERNANCE	
L3-702 BI Visit MP&S CNR Doc	**Data Collection** The service should collect and submit: a. Paediatric Intensive Care Audit Network (PICANet) data for submission to PICANet as soon as possible and no later than three months after discharge from the PCC Unit b. Paediatric Critical Care Minimum Data Set for submission to PICANet and SUS c. 'Quality Dashboard' data as recommended by the PCC CRG d. National PIC bed monitoring systems *Note: The PICANet Annual Report provides the documentation required for showing compliance with 'a'.*
L3-703 BI Visit MP&S CNR Doc	**Audit and Quality Improvement** The service should have a rolling programme of audit, including at least: a. Audit of implementation of evidence based guidelines (QS L3-500s) b. Participation in agreed national and network-wide audits c. Discharges between 22.00 and 06.59 d. Number of operations cancelled on the day of surgery due to the lack of a paediatric critical care bed *Note: The rolling programme should ensure that action plans are developed following audits and their implementation is monitored.*
L3-704 BI Visit MP&S CNR Doc	**Key Performance Indicators** Key performance indicators should be reviewed regularly with hospital (or equivalent) management and with commissioners: a. 'Quality Dashboard' data as recommended by the PCC CRG b. Average occupancy exceeding 85% for more than two successive months should be escalated to hospital management and to commissioners and should be specifically reviewed
L3-705 BI Visit MP&S CNR Doc	**Research** The service should actively participate in research relating to paediatric critical care. *Note: This is a desirable Quality Standard and may be not applicable if appropriate support for research is not available locally.*
L3-706 BI Visit MP&S CNR Doc	**Annual Report** The service should produce an annual report summarising activity, compliance with quality standards, 'Quality Dashboard' and clinical outcomes. The report should identify actions required to meet the expected Quality Standards and progress since the previous year's annual report. The report should be shared with referring hospitals.

Ref.	Quality Standard
L3-798 BI Visit MP&S CNR Doc	**Review and Learning** The service should have appropriate multi-disciplinary arrangements for: a. Review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses' b. Review and dissemination of published scientific evidence relating to paediatric critical care *Notes:* *1 These arrangements should include feedback to operational staff and should link with Hospital-Wide governance arrangements.* *2 This QS is additional to Paediatric Critical Care Network review and learning (QS N-798).* *3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.*
L3-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines and should comply with hospital document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

SPECIALIST PAEDIATRIC TRANSPORT SERVICES

These Standards are additional to the Hospital-Wide Standards and apply to services that are commissioned to undertake transfer of critically ill children, whether commissioned to provide ground transfers, air transfers or both ground and air transfers. Specialist Paediatric Transport Services may be delivered independently to a Level 3 PCCU or as an integrated service with a Level 3 PCCU. Aeromedical transfers include those undertaken using rotary wing or fixed wing vehicles. Additional guidance on transfer of critically ill children, including those needing ECMO, is available on the PICS website: http://picsociety.uk/ .

Ref.	Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
T-101 BI Visit MP&S CNR Doc	**Information for Parents** Parents of children needing transfer should be given written information regarding transport options, directions, car parking, accommodation and contact numbers for both the hospital and the unit to which their child is being transferred.
T-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 received b. Receiving feedback from referring hospitals and L2 and L3 PCC Units to which children are transferred c. Involving children and families, referring hospitals and L2 and L3 PCC Units to which children are transferred in decisions about the organisation of the service d. Examples of changes made as a result of feedback and involvement of children and families, referring hospitals and units to which children are transferred *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to the Specialist Paediatric Transport Service can be identified.*
STAFFING	
T-201 BI Visit MP&S CNR Doc	**Lead Consultant/s and Lead Nurse/s** A nominated lead consultant and lead nurse for the Specialist Paediatric Transport Service should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services for ground and for air transport (as applicable). The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the Specialist Paediatric Transport Service. *Note: If the Specialist Paediatric Transport Service provides both air and ground transport, the lead consultant and lead nurse may take responsibility for both services or there may be separate lead consultants and lead nurses for ground and air transport.*

Ref.	Standard
T-202 BI Visit MP&S CNR Doc	**Staff Authorised to Undertake Emergency Transfers** The nominated lead consultant and lead nurse for the Specialist Paediatric Transport Service should specify which staff are appropriately trained and experienced to carry out emergency transfers and whether or not direct consultant supervision is required. *Note: In compiling the list of authorised staff, account should be taken of the extent of recent experience of individual members of staff, whether appropriate Continuing Professional Development has been undertaken and whether staff are familiar with the equipment currently used by the Specialist Paediatric Transport Service. The National Generic Paediatric Critical Care Transport Passport, available on the PICS website http://picsociety.uk/, may be helpful in compiling the list of authorised staff.*
T-203 BI Visit MP&S CNR Doc	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. Staff should have competences in providing Level 3 paediatric critical care and appropriate competences in emergency transfer. A training and development plan for achieving and maintaining competences should be in place. All staff working on the Specialist Paediatric Transport Service should be undertaking Continuing Professional Development of relevance to their work within the Specialist Paediatric Transport Service. *Notes:* *1 Competences in providing Level 3 paediatric critical care are described in QSs **-202,203,206 and 208. QS **-203 gives more detail of the expected competences for the clinician with Level 2 RCPCH competences and equivalent staffing models.* *2 This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews. Appraisals and PDRs are sufficient for maintenance of competence. Details of individual appraisals and PDRs are **not** required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and / or where competence may not be maintained by the individual's usual clinical practice.* *3 For compliance with this QS the service should provide:* a. *A matrix of the roles within the service, competences expected and approach to maintaining competences* b. *A training and development plan showing how competences are being achieved and maintained.* *4 Training may be delivered through a variety of mechanisms, including e-learning, Hospital-Wide training and departmental training.* *5 Staff undertaking aeromedical transfers should have competences, training and CPD appropriate to this work covering, at least, aeromedical physiology, survival, hazardous materials, air-side safety, Crew Resource Management and human factors. Helicopter Underwater Escape Training should be undertaken if appropriate or if required by the aircraft operator. Training should include training relevant to the aircraft operator used by the service.* *6 The National Generic Paediatric Critical Care Transport Passport, available on the PICS website http://picsociety.uk/, and RCN 'Nursing on the move – specialist nursing for patients requiring repatriation and retrieval' (2013 or updated version) provide guidance on appropriate transport competences.*

Ref.	Standard
T-204 BI Visit MP&S CNR Doc	**Staffing Levels and Skill Mix** Sufficient staff with competences in providing Level 3 paediatric critical care and appropriate competences in emergency transfer should be available for the: a. Types of emergency transfers for which the service is commissioned b. Number of patients usually cared for by the service c. Usual case mix of patients As a minimum, the following staff with appropriate competences who have been authorised to undertake emergency transfers should be immediately available at all times: i. Consultant for advice and to join the emergency transfer team if necessary (24/7) ii. A clinician competent to lead the emergency transport iii. A nurse or other registered healthcare professional *Notes:* *1 Specialist Paediatric Transport Service staff may support L3 PCCU if not required for an* emergency transfer *so long as they are immediately available to the Specialist Paediatric Transport Service when required. The consultant on call for the Specialist Paediatric Transport Service should not be providing cover for L3 PCCU at the same time.* *2 The National Generic Paediatric Critical Care Transport Passport, available on the PICS website http://picsociety.uk/, gives guidance on competences for emergency transport.* *3 If 'ii' is achieved by a consultant based with the Specialist Paediatric Transport Service then a second consultant to provide advice to referring services for the duration of the emergency transfer is required.*
T-205 BI Visit MP&S CNR Doc	**Indemnity** Staff working on the Specialist Paediatric Transport Service must be: a. Indemnified for their practice in all environments in which they work b. Insured for personal injury sustained in the course of their professional work *Notes:* *1 Hospitals are responsible for ensuring this QS is met. At the time of publication, additional cover is provided by PICS membership.* *2 If the service provides aeromedical transport then this must be specifically referenced within the insurance documentation.*
T-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Note: The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*
FACILITIES AND EQUIPMENT	
T-401 BI Visit MP&S CNR Doc	**Voice Communication** The Specialist Paediatric Transport Service should have 24/7: a. A dedicated phone line for referrals from referring hospitals with the facility to record calls b. Conference call facility c. Facilities to contact specialist teams throughout the emergency transfer, including during transport *Note: Special arrangements may need to be made to ensure continuity of communications during aeromedical transport.*

Ref.	Standard
T-402 BI Visit MP&S CNR Doc	**Emergency Transport Arrangements** The Specialist Paediatric Transport Service should have arrangements for emergency transport covering at least: a. Emergency ambulance transport i. contact arrangements and response times ii. vehicle specification iii. restraint of children, equipment, staff and parents during transfer. iv. competence of drivers v. use of traffic law exemptions and duty hours limitations b. Air transport compliant with European Aeromedical Institute / Commission on Accreditation of Medical Transport Systems (CAMTS) Standards (if provided) *Notes:* *1 All vehicles (ground and air, stretchers, trolleys and medical equipment should comply with the most recent regulations and standards. Fixed wing aircraft should be capable of being pressurised with a cabin altitude not greater than 8000 feet (2440m).* 2 *If parents travel with their child in the ambulance then the Service Level Agreement with the ambulance service must include insurance of parents.* *3 All drivers should be trained to the core competences in the Driving Standard Agency 'Blue Light Expectations' or to the Royal Society for the Prevention of Accidents or equivalent standard.* *4 Arrangements for air transport should cover operating procedures, quality and safety systems.*
T-403 BI Visit MP&S CNR Doc	**Equipment** The equipment used by Specialist Paediatric Transport Service should be appropriate for the age, weight, therapies and monitoring needs of the children transported. Drugs and equipment should be checked in accordance with local policy.
GUIDELINES AND PROTOCOLS	
T-501 BI Visit MP&S CNR Doc	**Referral Handling** Guidelines on handling of referrals should be in use covering at least: a. Advice b. Decision support and triage c. Documenting the advice given and triage decision
T-502 BI Visit MP&S CNR Doc	**Service Guidelines** Guidelines should be in use covering at least: a. Staff fatigue (especially single driver operations) b. Moving and handling c. Health and safety d. Restraint of equipment, patient, staff and parents e. Infection control *Note: The guidelines should cover: footwear, helmets and flame retardant and reflective clothing, eye and ear protection and hazardous materials recognition and response.*

Ref.	Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
T-601 BI Visit MP&S CNR Doc	**Operational Policy** The Specialist Paediatric Transport Service should have an operation policy covering at least: a. Normal catchment population for the service and any normal inclusions / exclusions in terms of age and conditions of children to be transferred b. Types of emergency transfer for which the service is commissioned, including whether commissioned for ground transfers, air transfers or both ground and air transfers c. How information for referring hospitals will be communicated and updated (phone numbers and clinical information expected) d. Arrangements for ensuring arrival at the referring unit within three hours of the decision to transfer the child e. Authorisation of staff to undertake emergency transfers f. Roles within the emergency transfer team g. Risk assessment of each journey h. 'Blue light' use and Traffic Law exemptions i. Handover of clinical data to staff in L2 and L3 PCC Units j. Arrangements for transfer of at least one parent or carer k. Staff rostering to minimise fatigue and unplanned overtime l. Duty status during illness and pregnancy m. 'Surge' plan for days when the Specialist Paediatric Transport Service is not available or local capacity is exceeded n. Vehicle breakdown and accidents o. Incident reporting p. Agreed contribution to the network-wide training and CPD programme (QS N-206) *Notes:* *1 The normal catchment population and service inclusions / exclusions should be consistent with the contract for the service (QS C-603).* *2 Wherever possible and appropriate, one parent or carer should be given the option to accompany their child during emergency transfers. Where this is not possible or appropriate, other arrangements should be made to transfer parents.* *3 The policy on reporting of untoward clinical incidents should ensure that, where appropriate, clinical incidents should be reported to both the host organisation and referring hospital. Incident reporting arrangements should be consistent with network-agreed arrangements (QS N-601).* *4 In remote areas, where the Specialist Paediatric Transport Service has considerable distance to travel, emergency transfer team should arrive within four hours of the decision to transfer the child.* *5 Operational policies for ground and aeromedical transport services may be combined or may be separate. Aeromedical services should ensure 'n' and 'o' cover post-accident or incident planning and scenario training.*

Ref.	Standard
T-602 BI Visit MP&S CNR Doc	**Operational Policy – Aeromedical Transport** In addition to the requirements of QS T-601, the Operational Policy for aeromedical transport should cover: a. Multi-crew operation for all flights by pilots with competences in multi-crew operation b. Exceptional circumstances when an unfamiliar aircraft is used when SPTS staff should be accompanied by someone with competences relating to equipment and in-flight environment for the aircraft used c. Arrangements for 'turn down' or 're-referral' including information that should be provided to other aircraft providers or transport services d. Separation between clinical and aviation decision-making e. Carriage and use of hazardous materials, including nitric oxide, in all types of flying conditions f. Arrangements for joint induction and annual updates with aircraft providers covering Crew Resource Management (CRM), Threat and Error Management (TEM) and human factors *Note: This QS is applicable only to services providing aeromedical transport.*
GOVERNANCE	
T-701 BI Visit MP&S CNR Doc	**Data Collection** The Specialist Paediatric Transport Service should be collecting at least the following data for road and air (if provided) transfers: a. Referrals, including: i. those that do not result in transfer ii. those to which it is not able to respond b. Advice to referring hospitals c. Pre-transfer patient condition and management d. Paediatric Intensive Care Audit Network transport dataset for submission to PICANet as soon as possible and no later than three months after the transfer e. Untoward clinical incidents f. Mortality and morbidity g. 'Quality Dashboard' data as recommended by the PCC CRG These data should be collected for all children for whom emergency transfer was requested, including those not transferred by the Service. *Notes:* *1 Data on referrals to which the service cannot respond should ideally include data on referrals which are outside the remit for which the service is commissioning.* *2 Data should cover ground and / or aeromedical transport as relevant to the operation of the SPTS.*
T-702 BI Visit MP&S CNR Doc	**Audit and Quality Improvement** The service should have a rolling programme of audit, including of: a. Requests for emergency transfer to which it is not able to respond b. Time from decision to transfer to arrival at referring unit c. Transfers involving more than one journey d. Completeness of referral information e. Accuracy and completeness of transport records *Note: Audit should cover ground and / or aeromedical transport as relevant to the operation of the SPTS.*

Ref.	Standard
T-703 BI Visit MP&S CNR Doc	**Key Performance Indicators** Key performance indicators should be reviewed regularly with hospital (or equivalent) management and with commissioners including: a. Arrival at referring unit within three hours of the decision to transfer the child b. 'Quality Dashboard' data relating to transport as recommended by PCC CRG and / or the PICS Acute Transport Group *Notes:* *1 In remote areas, where the Specialist Paediatric Transport Service has considerable distance to travel, emergency transfer team should arrive within four hours of the decision to transfer the child. Paediatric Critical Care Operational Delivery Networks may agree local variation to target arrival times for particular referring units.* *2 Key performance indicators should apply to ground and / or aeromedical transport as relevant to the operation of the SPTS.*
T-704 BI Visit MP&S CNR Doc	**Annual Report** The Specialist Paediatric Transport Service should produce an annual report summarising activity, compliance with quality standards, and clinical outcomes. The report should identify actions required to meet expected quality standards and progress since the previous year's annual report. This report should be shared with referring hospitals. *Note: The annual report may form part of the L3 PCCU annual report or may be separate. The annual report should cover ground and / or aeromedical transport as relevant to the operation of the SPTS.*
T-798 BI Visit MP&S CNR Doc	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of and implementing learning from published scientific research and guidance *Note: Review and learning should cover ground and / or aeromedical transport as relevant to the operation of the SPTS and transport providers (ground and / or aircraft as applicable) should be part of the multi-disciplinary discussion.*
T-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines should comply with hospital (or equivalent) document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

PAEDIATRIC ANAESTHESIA AND GENERAL (ADULT) INTENSIVE CARE (GICU)

These Standards are additional to the Hospital-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 Specialist Paediatric Transport Service arrives. Specialist children's hospitals with a L3 PCCU are expected to meet the paediatric anaesthesia Standards but not the Standards for General Intensive Care Units.

Ref.	Quality Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
A-101 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 written in clear, simple language and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (DH, 2011).*
A-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 children and families may involve surveys, focus groups and / or other arrangements. They may be part of Hospital-Wide arrangements so long as issues relating to children's services can be identified.*
STAFFING	
A-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 children.*
A-202 BI Visit MP&S CNR Doc	**Lead Anaesthetist for Paediatric Critical Care (PCC Units only)** A nominated consultant anaesthetist should have lead responsibility for support to paediatric critical care *Note: This consultant may be the same as the lead anaesthetist (QS A- 201) or the GICU lead consultant (QS A-203) or may be different.*

Ref.	Quality Standard
A-203 BI Visit MP&S CNR Doc	**GICU Lead Consultant and Lead Nurse for Children** A nominated lead intensive care consultant and lead nurse should be responsible for Intensive Care Unit policies, procedures and training relating to the care of children. *Notes:* *1 This QS is not applicable if a General Intensive Care Unit is not one of the possible areas for maintenance of paediatric critical care (QS **-506).* *2 It is desirable in all units that the lead nurse is a senior nurse with specific competences in paediatric critical care.*
A-204 BI Visit MP&S CNR Doc	**On Site Anaesthetist** An anaesthetist, or other practitioner, with up to date competences in advanced paediatric resuscitation and life support and advanced airway management should be immediately available at all times. *Notes:* *1 'Immediately available' means able to attend within five minutes.* *2 This QS duplicates QS HW-204. It is included so that a full picture of paediatric anaesthesia responsibilities can be gathered. Notes to HW-204 also apply, in particular, note 4 explains that paediatric medical staff may provide the competences in advanced airway management of neonates.* *3 Achievement and maintenance of competences may be through appropriate in-house or other resuscitation and stabilisation courses or training related to children. The Royal College of Anaesthetists 'Guidance on the provision of paediatric anaesthesia services' (2014) states that "Anaesthetists who care for children should have received appropriate training and should ensure that their competency in anaesthesia and resuscitation is adequate for the management of the children they serve….. Some anaesthetists working in non-specialist centres will not have regular children's lists but may have both daytime and out-of-hours responsibility to provide care for children requiring emergency surgery. There should be arrangements for undertaking regular supernumerary attachments to lists or secondments to specialist centres. The Certificate of Fitness for Honorary Practice may facilitate such placements and provides a relatively simple system for updates in specialist centres. Paediatric simulator work may also be useful in helping to maintain paediatric knowledge and skills……Therefore, all anaesthetists should maintain paediatric resuscitation skills unless they work in a unit which does not have open access for children.".*
A-205 BI Visit MP&S CNR Doc	**Consultant Anaesthetist 24 Hour Cover** A consultant anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management who is able to attend the hospital within 30 minutes and does not have responsibilities to other hospital sites should be available 24/7. *Notes:* *1 This QS duplicates QS HW-205. It is included so that a full picture of paediatric anaesthesia responsibilities can be gathered.* *2 As QS A-204 note 3.*
A-206 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 competences in advanced paediatric resuscitation and life support and advanced paediatric airway management**.** *Note: As QS A-204 note 3.*

Ref.	Quality Standard
A-207 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.*
A-208 BI Visit MP&S CNR Doc	**Operating Department Assistance** Operating department assistance from personnel trained and familiar with paediatric work and competences in basic paediatric resuscitation and life support 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.*
A-209 BI Visit MP&S CNR Doc	**Recovery Staff** At least one member of the recovery room staff with paediatric resuscitation and life support competences should be available for all children's operating lists.
FACILITIES AND EQUIPMENT	
A-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 include visual and, ideally, sound separation from adult patients.*
A-403 BI Visit MP&S CNR Doc	**Drugs and Equipment** Appropriate drugs and equipment should be available in each area in which anaesthesia is delivered to children. Drugs and equipment should be checked in accordance with local policy. *Note: A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
A-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 paediatric critical care for children. Drugs and equipment appropriate to the age and condition of children who may be admitted (QS **-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 paediatric critical care (QS **-506).*
GUIDELINES AND PROTOCOLS	
A-501 BI Visit MP&S CNR Doc	**Role of Anaesthetic Service in Care of Critically Ill Children** Protocols for resuscitation, stabilisation, accessing advice, maintenance and transfer and of critically ill children and the provision of paediatric critical care should be clear about the role of the anaesthetic service and General Intensive Care Unit (if applicable) in each stage of the child's care.

Ref.	Quality Standard
A-502 BI Visit MP&S CNR Doc	**GICU Care of Children** If the maintenance guidelines in QS **-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. Availability of a registered children's nurse to support the care of the child and to review the child at least every 12 hours c. Discussion with a L3 PCC consultant about the child's condition prior to admission and regularly during their stay on the General Intensive Care Unit d. Agreement by a local paediatrician to the child being moved to the Intensive Care Unit e. Availability of a local paediatrician for advice f. Review of the child by a senior member of the paediatric team at least every 12 hours during their stay on the General Intensive Care Unit g. 24 hour access for parents to visit their child *Notes:* *1 This QS is not applicable if a General Intensive Care Unit is not one of the possible areas for maintenance of paediatric critical care (QS **-506). The criteria for admission should be consistent with the agreed network criteria (QSs N-502 & 503).* *2 The requirement for discussion with L3 PCCU does not apply to children aged over 16 for whom use of adult facilities is considered appropriate.* *3 The frequency of discussions with a L3 PCC consultant is not specified but should be agreed between the GICU consultant and the L3 PCC consultant. More frequent discussions are likely to be needed for younger or sicker patients.*
A-503 BI Visit MP&S CNR Doc	**Clinical Guidelines - Anaesthesia** Clinical guidelines should be in use covering: a. Pain management for children b. Pre-operative assessment c. Preparation of all children undergoing general anaesthesia d. Difficult airway management
A-598 BI Visit MP&S CNR Doc	**Implementation of Hospital Guidelines** Staff should be aware of and following hospital guidelines: a. Surgery and anaesthesia for children (QS HW-502) b. Consent c. Organ and tissue donation d. Staff acting outside their area of competence *Note: As QSs HW-502 and HW-598.*
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
A-601 BI Visit MP&S CNR Doc	**Liaison with Theatre Manager** There should be close liaison between the lead consultant for paediatric anaesthesia (QS A-201) and the Theatre Manager with regard to the training and mentoring of support staff.

Ref.	Quality Standard
A-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.
GOVERNANCE	
A-701 BI Visit MP&S CNR Doc	**GICU Critical Care Minimum Data Set** The critical care minimum data set collected and submitted to SUS should include data on children and young people admitted to the unit. *Note: This QS is not applicable if a General Intensive Care Unit is not one of the possible areas for maintenance of paediatric critical care (QS **-506).*
A-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'. *Notes:* *1 These arrangements should include feedback to operational staff and should link with Hospital-Wide governance arrangements.* *2 This QS is additional to paediatric critical care network review and learning (QS N-798).* *3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.*
A-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines and should comply with hospital document control procedures. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

PAEDIATRIC CRITICAL CARE OPERATIONAL DELIVERY NETWORKS

This section covers operational delivery of paediatric critical care across a network of hospitals with at least one Level 3 Paediatric Critical Care Unit and at least one Specialist Paediatric Transport Service. Integrating the operational delivery of urgent care, trauma care, neonatal care and other children's services (including cardiac, neurosciences and surgery) will be undertaken by other networks and is not covered here. Paediatric Critical Care Operational Delivery Networks will, of course, need to work in liaison with these networks.

A typical paediatric critical care network will comprise a large number of L1 PCCUs (at least one in each hospital with in-patient paediatrics), a smaller number of L2 PCCUs (in larger or more geographically isolated hospitals), one or more L3 PCCUs, and one Specialist Paediatric Transport Service.

Ref	Standard
INFORMATION AND SUPPORT FOR CHILDREN AND THEIR FAMILIES	
N-199 BI Visit MP&S CNR Doc	**Involving Children and Families** The network should have mechanisms for: a. Receiving feedback from children and families about the treatment and care they receive across patient pathways b. Involving children and families in decisions about the organisation of the network c. Examples of changes made as a result of feedback and involvement of children and families *Note: The arrangements for receiving feedback from patients and carers may involve surveys, focus groups and / or other arrangements.*
STAFFING	
N-201 BI Visit MP&S CNR Doc	**Network Lead Consultant and Lead Nurse** The network should have an identified lead consultant and lead nurse with time identified in their job plans for their work in the network. The lead consultant and lead nurse should undertake regular clinical work in a Paediatric Critical Care Unit or the Specialist Paediatric Transport Service.
N-202 BI Visit MP&S CNR Doc	**Network Manager** The network should have an identified Network Manager with time allocated for this work. *Note: Network Manager posts may be shared with other neonatal or paediatric networks or with adult critical care networks.*
N-203 BI Visit MP&S CNR Doc	**Educator** The network should have an identified educator to support the delivery of the network training and CPD programme (QS N-206). *Note: Educator posts may be shared with other neonatal or paediatric networks or with adult critical care networks. Larger networks may require more than one educator.*

Ref	Standard
N-204 BI Visit MP&S CNR Doc	**Competence Framework** The network should have agreed a competence framework giving guidance to constituent PCC Units on the competences needed by staff providing paediatric critical care. *Notes:* *1 'High Dependency Care for Children - Time to Move On' (RCPCH, 2014) gives more detail of the expected paediatric critical care competences which should be achieved within 12 months of starting work on a PCCU.* *2 Further detail of competences in paediatric critical care is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .*
N-205 BI Visit MP&S CNR Doc	**Network Training Needs Analysis** The network should have undertaken an analysis of the training needs of constituent services in order for staff to achieve the expected competences (QS **-207).
N-206 BI Visit MP&S CNR Doc	**Network-wide Training and CPD Programme** The network should ensure availability of a range of opportunities for network-wide training and CPD covering, at least: a. Resuscitation and stabilisation of the sick child and maintenance until arrival of the Specialist Paediatric Transport Service b. Emergency transfer c. Paediatric critical care d. Opportunities for supernumerary clinical practice in other services within the network e. Achievement and maintenance of competences through CPD *Notes:* *1 Opportunities for supernumerary clinical practice will normally be in high volume or more specialist services. These may be supported by the use of 'Certificates of Fitness for Honorary Practice' and 'NHS Education Passports'.* *2 Network Training and CPD opportunities should cover the needs of paediatric, anaesthetic, general / adult critical care and Emergency Department staff as well as those of staff working in paediatric critical care services.*
N-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support for the work of the network should be available. *Note: The amount of administrative, clerical and data collection support is not strictly defined but should be sufficient to ensure that clinical staff are not spending inappropriate amounts of time on administrative and data collection work.*

Ref	Standard
GUIDELINES AND PROTOCOLS	
N-501 BI Visit MP&S CNR Doc	**Patient Pathways** The network should agree patient pathways, including trigger points for discussion of patients with the network Specialist Paediatric Transport Service, covering at least: a. Acute respiratory failure (including bronchiolitis and asthma) b. Sepsis (including septic shock and meningococcal infection) c. Management of diabetic ketoacidosis d. Seizures and status epilepticus e. Trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable) f. Cardiac arrhythmia g. Upper airway obstruction h. Long-term ventilation i. Care of young people aged 16 to 18 j. Rehabilitation after critical illness *Notes:* *1 Long-term ventilation pathways should be developed in collaboration with Children's Long-Term Ventilation Networks (or equivalent).* *2 Collaboration with other networks will be needed for the development of some patient pathways, for example, with trauma, neonatal and adult critical care networks.*
N-502 BI Visit MP&S CNR Doc	**Network Capacity Plan** The network should have an agreed capacity plan covering times when need for L3 PCC exceeds the capacity available. This plan should be updated annually.
N-503 BI Visit MP&S CNR Doc	**Network Guidance** The network should have agreed guidance for its constituent organisations on at least: a. A standardised early warning system for use across the network covering observation, monitoring and escalation of care b. Access to neuro-radiology and specialist paediatric reporting, including arrangements for image transfer c. Arrangements for 'back transfers' from L3 and L2 PCC Units to other units within the network d. Criteria for admission of children to General (adult) Intensive Care Units

Ref	Standard
SERVICE ORGANISATION AND LIAISON WITH OTHER SERVICES	
N-601 BI Visit MP&S CNR Doc	**Network Establishment and Operational Policy** Organisations participating in the network should have agreed the membership, roles, responsibilities and accountability of the network. The network operational policy should cover: a. Agreed terms of reference b. Defined host organisation for the network c. Organisations who are part of the network including, at least, all PCC Units and the Specialist Paediatric Transport Service/s d. Involvement of anaesthetic and general (adult) critical care services of the network e. Involvement of patients and carers in the work of the network f. Mechanism for reporting, dealing with and learning from critical incidents involving more than one service within the network g. Mechanisms for linking with the work of other relevant networks *Notes:* *1 Examples of other relevant networks are trauma, children's surgery, adult critical care, neonatal critical care, paediatric neurosciences, paediatric cardiac and burns networks.* *2 Networks may be accountable to one organisation on behalf of others or to constituent organisations' Chief Executives with one organisation taking a lead role.*
N-602 BI Visit MP&S CNR Doc	**Network Service Configuration** The network should agree advice to commissioners on: a. Configuration of Paediatric Critical Care Units across the network b. Interventions offered by each Level 1 and Level 2 PCC Unit c. Names to be used for each type of PCC Unit within the network d. Network Specialist Paediatric Transport Service/s *Notes:* *1 The 'configuration of paediatric critical care services' means which units within the network should be providing L1, L2 and L3 paediatric critical care. Formal designation will be undertaken by commissioners (QS C-603).* *2 Level 2 Units should all provide acute (and chronic) non-invasive ventilation (both CPAP and BiPAP support) and care for children with tracheostomies and children on long-term ventilation. Some Level 2 Units, typically within a specialist children's hospital, may provide additional interventions such as care of children undergoing intracranial pressure monitoring or acute renal replacement therapy. Some Level 1 Units may be designated to provide CPAP to certain patient groups, for example, patients with bronchiolitis.*

Ref	Standard
GOVERNANCE	
N-701 BI Visit MP&S CNR Doc	**Network Data Collection** The network should ensure that all L2 and L3 PCC Units are collecting and submitting: a. Paediatric Intensive Care Audit Network data for submission to PICANet in accordance with PICANet quality standards for collection and submission b. Paediatric Critical Care Minimum Data Set for submission to PICANet and SUS c. Quality Dashboard data as recommended by the PCC Clinical Reference Group d. National PIC bed monitoring systems (L3 PCCUs only) *Note: Implementation of this QS for L2 PCCUs is dependent on PICANet being contracted and funded for handling these data. Collection by L1 Units is desirable but not yet expected for compliance with this QS.*
N-702 BI Visit MP&S CNR Doc	**Network Audit** The network should have an ongoing programme of audit covering at least: a. Activity and outcomes as shown by PICANet, PCC Minimum Data Set and 'Quality Dashboard' data b. Adherence to network-agreed patient pathways (QS C-501)
N-703 BI Visit MP&S CNR Doc	**Network Quality Assurance** The network should ensure a programme of assurance of compliance with Quality Standards for the Care of Critically Ill Children covering services across the network is run at least every five years. *Note: Peer review would provide an appropriate form of quality assurance for network services.*
N-704 BI Visit MP&S CNR Doc	**Network Annual Meeting and Annual Report** The network should hold an Annual Meeting to agree the annual work plan and discuss the network Annual Report.
N-705 BI Visit MP&S CNR Doc	**Network Risk Register** The network should maintain a risk register, including recording risks and action taken to address or mitigate risks. The network risk register should be clear about its relationship with the risk register of individual services or organisations.
N-798 BI Visit MP&S CNR Doc	**Network Multi-disciplinary Review and Learning** The network should have arrangements for multi-disciplinary review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'. *Note: Network review and learning arrangements should specifically cover care across patient pathways within the network.*
N-799 BI Visit MP&S CNR Doc	**Network Document Control** All network pathways, guidelines and protocols should meet reasonable standards of document control. *Note: Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of hospital document control policies are not required.*

COMMISSIONING

In England these Quality Standards should be met by NHS England commissioners of specialised services or Clinical Commissioning Groups or by commissioners working together. NHS England commissioners of specialised services are responsible for commissioning Levels 2 and 3 paediatric critical care. Clinical Commissioning Groups are responsible for commissioning Level 1 paediatric critical care. 'High Dependency Care for Children - Time to Move On' (RCPCH, 2014) recommends that NHS England commissioners of specialised services have overall responsibility for the entire pathway for children needing critical care.

Ref.	Standard
C-601 BI Visit MP&S CNR Doc	**Paediatric Critical Care Needs Assessment and Strategy** Commissioners should have an agreed paediatric critical care: a. Needs assessment b. Strategy for the development of services across the Paediatric Critical Care Operational Delivery Network
C-602 BI Visit MP&S CNR Doc	**Commissioning: Urgent Care for Children** Urgent care for children from the network's population should be commissioned including: a. Emergency Centres b. Trauma services for children and their designation c. Children's Assessment Services *Notes:* *1 Hospitals accepting children with trauma should also provide on the same hospital site:* *a. Either: A L1 or L2 PCC Unit and a General Intensive Care Unit which admits children needing a short period of post-anaesthetic care or maintenance prior to transfer to L3 PCC (QS **-506)* ***Or:** Level 3 PCCU* *b. Acute pain service.* *2 Children's assessment services should be sited alongside either an Emergency Department or an in-patient children's service (or PCCU).* *3 This QS may be met by Urgent Care Networks on behalf of Commissioners.*

Ref.	Standard
C-603 BI Visit MP&S CNR Doc	**Commissioning: Paediatric Critical Care** Paediatric critical care services for the network population should be commissioned including: a. Level 1 paediatric critical care service/s b. Level 2 paediatric critical care service/s c. Level 3 paediatric critical care services/s d. Specialist Paediatric Transport Service, including whether commissioned for aeromedical transfers e. Extracorporeal membrane oxygenation f. Services for children needing long-term ventilation g. Paediatric Critical Care Operational Delivery Network/s The specification for each service should cover: i. Inclusions and exclusions in terms of age and conditions of children for which the service is responsible ii. Interventions to be offered in each PCCU iii. Key performance indicators *Notes:* *1 This QS may be met by NHS England commissioners of specialised services or Clinical Commissioning Group commissioners or by commissioners working together. 'High Dependency Care for Children - Time to Move On' (RCPCH, 2014) recommends that NHS England commissioners of specialised services have responsibility for oversight of the whole paediatric critical care pathway.* *2 Hospitals with in-patient paediatric facilities including hospitals providing elective in-patient or emergency surgery should have a unit providing at least Level 1 paediatric critical care on the same hospital site.* *3 Level 2 Units should all provide acute (and chronic) non-invasive ventilation (both CPAP and BiPAP support) and care for children with tracheostomies and children on long-term ventilation. Some Level 2 Units, typically within a specialised children's hospital, may provide additional interventions such as care of children undergoing intracranial pressure monitoring or acute renal replacement therapy. A number of L1 Units may be designated by their network to deliver CPAP to certain patient groups, for example, patients with bronchiolitis.* *4 The Specialist Paediatric Transport Service should be commissioned separately from L3 PCC with separately identified activity and funding. Combined paediatric and neonatal specialist transport services are acceptable for compliance with this QS. Specialist Paediatric Transport Services should be commissioned to undertake transfers of children to Level 2 and Level 3 PCCUs.* *5 ECMO may be commissioned from the network L3 PCCU or may be separately commissioned.* *6 Specifications should be clear about the care of young people aged 16 to 18, who should normally be given the choice of care in a paediatric or adult facility, and about the care of pre-term babies who have been discharged from neonatal units.* *7 It is desirable that specifications for L3 PCCUs and SPTS include their expected contribution to the network-wide training and CPD programme (QS N-206).* *8 Quality Standards for commissioning of long-term ventilation are given in the WMQRS Quality Standards for Services providing Long-Term Ventilation for Children and Young People.*
C-604 BI Visit MP&S CNR Doc	**Paediatric Critical Care Operational Delivery Network** Commissioners should agree the catchment population, organisations involved and host organisation for the Paediatric Critical Care Operational Delivery Network/s within the area for which they are responsible.

Ref.	Standard
GOVERNANCE	
C-701 BI Visit MP&S CNR Doc	**Paediatric Critical Care Quality Monitoring** Commissioners should monitor at least annually key performance indicators and aggregate data on activity and outcomes from each paediatric critical care service, including: **L3 PCCU:** All instances of average occupancy exceeding 85% for more than two successive months **SPTS**: Arrival at referring unit within three hours of the decision to transfer the child *Note: Clinical Quality Review Meetings are sufficient for compliance with this QS **only** if there is evidence of discussion of the specific service.*

APPENDIX 1 STEERING GROUP

PAEDIATRIC INTENSIVE CARE SOCIETY STANDARDS STEERING GROUP

Name	Organisation
John Alexander	West Midlands Care of Critically Ill Children Steering Group
Oliver Bagshaw	Association of Paediatric Anaesthetists
Craig Brown	Intensive Care Society / Faculty of Intensive Care Medicine
Julia Grace	Paediatric Critical Care Clinical Reference Group
Jane Eminson	West Midlands Quality Review Service
Yvonne Heward	Paediatric Intensive Care Society (Nurse Vice-President)
Caroline Lamming	Paediatric Intensive Care Audit Network (PICANet)
Mike Linney	Royal College of Paediatrics and Child Health
Daniel Lutman	Paediatric Intensive Care Society Acute Transport Group
Fiona Lynch	Paediatric Intensive Care Society (Nurse Vice-President)
Gary Masterson	Intensive Care Society / Faculty of Intensive Care Medicine
Patricia McCreedy	British Association of Critical Care Nurses
Kevin Morris (Chair)	Paediatric Intensive Care Society (Past-President)
Linda Partridge	WellChild Charity
Kay Rushforth	Royal College of Nursing
Liz Saunders	College of Emergency Medicine
Rick Turnock / Simon Hoddart	British Association of Paediatric Surgeons
Peter Wilson	Paediatric Intensive Care Society (President)

APPENDIX 2 GUIDANCE / REFERENCE SOURCES

Year	Publisher	Title	No.
Undated	NHS England	Service Specification E07/s/a: level 3 Paediatric Critical Care	5
Undated	NHS England	Service Specification E07/S/b: Level 2 Paediatric Critical Care	4
Undated	NHS England	Service Specification E07/S/d: Paediatric Critical Care Transport	3
2015	NHS England	Transforming urgent and emergency care services in England	6
2015	Paediatric Intensive Care Audit Network	November 2015 Annual Report	
2015	Royal College of Paediatrics and Child Health	Facing the Future: Standards for acute general paediatric services	2
2015	Royal College of Paediatrics and Child Health	Facing the Future: Together for child health	7
2015	Royal College of Paediatrics and Child Health	Making decisions to limit treatment in life-limiting and life-threatening conditions in children: a framework for practice	
2015	Royal College of Paediatrics and Child Health	The diagnosis of death by neurological criteria in infants less than two months old	
2015	Royal College of Surgeons of England	Standards for Non-Specialist Emergency Surgical Care of Children	12
2015	The National Institute for Health and Care Excellence	Safe staffing for nursing in A&E departments. Draft for consultation, 16 January to 12 February 2015	
2015	The Royal College of Anaesthetists	Guidelines for the Provision of Paediatric Anaesthetic Services	13
2014	National Confidential Enquiry into Patient Outcome and Death	On the Right Trach? A review of the care received by patients who underwent a tracheostomy	
2014	NHS England	Safer Staffing: A Guide to Care Contact Time	11
2014	Royal College of Paediatrics and Child Health	High Dependency Care for Children - Time To Move On	1
2013	Children's Surgical Forum	Standards for Children's Surgery	
2013	Royal College of Nursing	Defining staffing levels for children and young people's services	10
2013	Royal College of Nursing	Nursing on the move - specialist nursing for patients requiring repatriation and retrieval	14
2012	Academy of Medical Royal Colleges	Seven Day Consultant Present Care	
2012	Royal College of Paediatrics and Child Health	Consultant Delivered Care. An evaluation of new ways of working in Paediatrics	8
2012	Royal College of Paediatrics and Child Health	Standards for Children and Young People in Emergency Care Settings	9

Year	Publisher	Title	No.
2012	Royal College of Paediatrics and Child Health	Bringing Networks to Life - An RCPCH guide to implementing Clinical Networks	
2011	Royal College of Paediatrics and Child Health	Facing the Future: A Review of Paediatric Services	
2011	Department of Health	Quality Criteria for Young People Friendly Health Services	15
2011	The College of Emergency Medicine	Emergency Medicine Operational Handbook: The Way Ahead. Version 2	
2011	Royal College of Paediatrics and Child Health	Quality and Safety Standards for Small and Remote Paediatric Units	
2011	Royal College of General Practitioners, The College of Emergency Medicine, Royal College of Paediatrics and Child Health	Urgent and Emergency Care Clinical Audit Toolkit	
2010	Royal College of Surgeons of England	Ensuring the Provision of General Paediatric Surgery in the District General Hospital - Guidance to Commissioners and Service Planners	
2010	Royal College of Paediatrics and Child Health, Royal College of Nursing	Maximising Nursing Skills in Caring for Children in Emergency Departments	
2009	Department of Health, Department for Children, Schools and Families	Healthy lives, brighter future: The strategy for children and young people's health	
2009	Royal College of Paediatrics and Child Health	RCPCH guidance on the role of the consultant paediatrician in providing acute care in hospital	
2009	Royal College of Paediatrics and Child Health	Short Stay Paediatric Assessment Units: Advice for Commissioners and Providers	
2008	Department of Health	Commissioning Safe and Sustainable Specialised Paediatric Services	16
2008	Royal College of Paediatrics and Child Health	Supporting Paediatric Reconfiguration: A Framework for Standards	
2008	Royal College of Paediatrics and Child Health	The Role of the Consultant Paediatrician with Subspecialty Training in Paediatric Emergency Medicine	
2008	Confidential Enquiry into Maternal and Child Health	Why Children Die: A Pilot Study	
2008	NHS Institute for Innovation and Improvement	Focus on: Children and Young People Emergency and Urgent Care Pathway	
2007	General Medical Council	0 - 18 Years: Guidance for all Doctors	
2007	Royal College of Paediatrics and Child Health	Direction of Travel for Urgent Care: Response from the Royal College of Paediatrics and Child Health	
2007	Commission for Healthcare Audit and Inspection	Improving Services for Children in Hospital	
2007	Royal College of Paediatrics and Child Health	Modelling the Future: A consultation paper on the future of children's health services	

Year	Publisher	Title	No.
2007	Royal College of Paediatrics and Child Health	Services for Children in Emergency Departments: Report of the Intercollegiate Committee for Services for Children in Emergency Departments	
2007	Royal College of Surgeons of England	Surgery for Children - Delivering a First Class Service	
2006	Scottish Executive	Emergency Care Framework for Children & Young People in Scotland	
2006	Department of Health	The acutely or critically sick or injured child in the district general hospital. A team response	
2005	Welsh Assembly	Children's National Service Framework for Wales. Acute and Chronic Illness or Injury	
2004	Department of Health	National Service Framework for Children, Young People and Maternity Services	
2003	Department of Health	Getting the right start: National Service Framework for Children. Standard for Hospital Service	
2002	Department of Health	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	
2002	Paediatric Intensive Care Society	Standards for Bereavement Care	
2000	Department of Health	Framework for the Assessment of Children in Need and their Families	
1999	Department of Health	Working Together to Safeguard Children	
1997	Action for Sick Children	Emergency Health Services for Children and Young People	
1997	NHS England	Paediatric Intensive Care - "A Bridge to the Future"	
1997	NHS England	Paediatric Intensive Care - "Framework for the Future"	
1994	Her Majesty's Stationery Office	The Allitt Inquiry: The Clothier Report	
1992	Her Majesty's Stationery Office	The United Nations Convention on the Right of the Child	
1989	Her Majesty's Stationery Office	Children Act	
1989	Department of Health	The Children Act - an Introductory Guide	

The table below shows links between the Quality Standards and key guidance documents. Quality Standards without a reference source are based on other guidance documents listed above, other WMQRS Quality Standards or on the consensus of the Steering Groups which developed the Standards.

QS reference	Key Guidance No.	QS reference	Key Guidance No.	QS reference	Key Guidance No.	QS reference	Key Guidance No.
HW-201		**-404		T-201	3	A-501	13
HW-202	3,4,5,12	**-405	13	T-202		A-502	13
HW-203		**-406		T-203	3,14	A-503	13
HW-204	9,12,13	**-501	6,9,12	T-204	3	A-598	12,13
HW-205		**-502	12	T-205	3	A-601	12,13
HW-206		**-503	9,12	T-299		A-602	13

QS reference	Key Guidance No.	QS reference	Key Guidance No.	QS reference	Key Guidance No.	QS reference	Key Guidance No.
HW-401		**-504		T-401		A-701	
HW-501	9,12,13	**-505	12	T-402	3	A-798	13
HW-502	12,13	**-506	3,12	T-403		A-799	
HW-598	12,13	**-507		T-501		N-199	
HW-602	3,4,9,13	**-508		T-502		N-201	
**-101	6,9	**-509	3,12,13	T-601	3	N-202	
**-102	12	**-598	12,13	T-602		N-203	
**-103	15	**-601	2,5,7,9,12	T-701	3	N-204	1
**-104		**-702	1,5	T-702	3	N-205	
**-105	9	**-703	9	T-703	3	N-206	3
**-196	9	**-704	5	T-704		N-299	
**-197	9	**-705		T-798		N-501	1,3,4,5,12, 13
**-199	9	**-706		T-799		N-502	5
**-201		**-798	5	A-101	12,13,15	N-503	1
**-202	1,2,3,8,9,13	**-799		A-199	12	N-601	1
**-203	1,3,8,12	ED-211		A-201	12	N-602	1
**-204		ED-212	6	A-202		N-701	1
**-205	2	ED-213		A-203		N-702	
**-206	1,4,5,6,9,10	ED-214		A-204	12,13	N-703	
**-207	1,6,9,10,11	ED-403	9	A-205	12	N-704	
**-208	1	ED-510		A-206	13	N-705	
**-209	6,9	ED-511		A-207	13	N-798	3
**-298	6,9	ED-512		A-208	12,13	N-799	
**-299		ED-602		A-209	12,13	C-601	
**-301	12	ED-603		A-401	12,13	C-602	6
**-302	4,5,16	ED-701	9	A-402	13	C-603	1,3,4
**-401	9,12,13	T-101	3,12	A-403	13	C-604	1,9
**-402	13	T-199	3	A-404	13	C-701	3,4

APPENDIX 3 GLOSSARY OF ABBREVIATIONS

The following abbreviations are used within the Quality Standards:

APLS	Advanced Paediatric Life Support
ARS	Advanced Respiratory Support
ATMIST	Age, Time, Mechanism of injury, Injuries, Signs, Treatment
BI	Background information for the review team
BiPAP	Bi-level Positive Airway Pressure
CAMTS	Commission on Accreditation of Medical Transport Systems
CAS	Children's Assessment Service
CNR	Case note review or clinical observation
CPAP	Continuous Positive Airway Pressure
CPD	Continuing Professional Development
CQC	Care Quality Commission
CRG	Clinical Reference Group
CT	Computerised Tomography
Doc	Documentation should be available
DH	Department of Health
ECG	Electrocardiogram
ECLS	Extracorporeal Life Support
ECMO	Extracorporeal membrane oxygenation
ED	Emergency Department
ENT	Ear Nose and Throat
EPLS	European Paediatric Life Support
EWTD	European Working Time Directive
GICU	General (Adult) Intensive Care Unit
GCS	Glasgow Coma Scale
HBN	Health Building Notes
HFOV	High Frequency Oscillatory Ventilation
HRG	Healthcare Resource Group
ICU	Intensive Care Unit
ICP	Intracranial Pressure
IMV	Invasive Mechanical Ventilation
iNO	Inhaled Nitric Oxide
IP	In-patient
IV	Intravenous
L1	Level 1 Critical Care Unit

L2	Level 2 Critical Care Unit
L3	Level 3 Critical Care Unit
MARS	Molecular Adsorbent Recirculating System
MP&S	Meeting patients, carers and staff
NHSLA	National Health Service Litigation Authority
PCC	Paediatric Critical Care
PCC MDS	Paediatric Critical Care Minimum Dataset
PCCU	Paediatric Critical Care Unit
PDR	Personal Development Review
PICANet	Paediatric Intensive Care Audit Network
PICM ISAC	Paediatric Intensive Care Medicine Intercollegiate Specialty Advisory Committee
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
SPTS	Specialist Paediatric Transport Service
ST	Specialist Trainee
SUS	Secondary Uses Service
VAD	Ventricular Assist Device
Visit	Visiting facilities
WMQRS	West Midlands Quality Review Service
WTE	Whole time equivalent

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 or clinical observation	A few Quality Standards require reviewers to look at case notes or other clinical information.
Documentation	These are policies, guidelines and other documentation that reviewers will need to see. Documentation may be in the form of a website or other social media.

The following table summarises the evidence needed for each Quality Standard.

QS Ref. No.	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
Ref.		BI	Visit	MP&S	CNR	DOC	
HW- STANDARDS							
HW-201	Board-Level Lead for Children	■					
HW-202	Clinical Leads	■					
HW-203	Trust-Wide Group			■		■	Terms of reference, membership, notes of recent meetings
HW-204	Paediatric Resuscitation Team			■		■	Operational policy
HW-205	Consultant Anaesthetist 24 Hour Cover			■		■	Recent rota
HW-206	Other Clinical Areas			■			
HW-401	Paediatric Resuscitation Team – Equipment		■	■			
HW-501	Resuscitation and Stabilisation					■	Operational policy
HW-502	Surgery and Anaesthesia Criteria			■		■	Clinical guidelines
HW-598	Trust-Wide Guidelines			■		■	Guidelines
HW-602	Paediatric Critical Care Operational Delivery Network Involvement			■		■	Notes of meetings attended. Examples of dissemination.
ED-, CA-, IP-, L1-, L2- & L3- STANDARDS							
-101	Child-friendly Environment		■	■			
-102	Parental Access and Involvement			■			
-103	Information for Children		■	■			

QS Ref. No.	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
Ref.		BI	Visit	MP&S	CNR	DOC	
-104	Information for Families						
-105	Facilities and Support for Families (In-patient and PCC Units only)						
-196	Discharge Information						
-197	Additional Support for Families						
-199	Involving Children and Families						Examples of changes made as a result of feedback
-201	Lead Consultant and Lead Nurse						
-202	Consultant Staffing						List of staff with details of paediatric resuscitation & life support competences
-203	'Middle Grade' Clinician						
-204	Consultants with Lead Responsibility (L3 PCC Units only)						
-205	Medical Staff: Continuity of Care (In-patient and PCC Units only)						Recent rota
-206	Competence Framework and Training Plan – Staff Providing Bedside Care						Competence framework describing the competences expected for roles within the service. Training and development plan to show how staff will achieve and maintain competences
-207	Staffing Levels: Bedside Care						Recent rotas Details of competences of staff on rotas Escalation policy Audit results (if achieved by flexible use of staff)
-208	New Starters (PCC Units only)						
-209	Other Staffing:						
-298	Safeguarding Training						Details of training undertaken by staff
-299	Administrative, Clerical and Data Collection Support						
-301	Imaging Services						
-302	Co-located Services (L2 & L3 PCC Units only)						
-401	Resuscitation Equipment						

QS Ref. No.	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
Ref.		BI	Visit	MP&S	CNR	DOC	
-402	'Grab Bag'						
-404	Facilities (PCC Units only)						
-405	Equipment (PCC Units only)						
-406	'Point of Care' Testing						
-501	Initial Assessment (N/A to L3 PCC Units)						Clinical guidelines or protocol
-502	Paediatric Early Warning System						Early warning system documentation
-503	Resuscitation and Stabilisation						Clinical guidelines or protocol
-504	Paediatric Advice (N/A to L3 PCC Units)						Clinical guidelines
-505	Clinical Guidelines						Clinical guidelines
-506	PCC Transfer Guidelines (N/A to L3 PCC Units)						Clinical guidelines
-507	In-hospital Transfer Guidelines						Clinical guidelines
-508	Inter-hospital Transfer Guidelines						Clinical guidelines
-509	Time-Critical or Unsafe Delay Transfer Guidelines						Clinical guidelines
-598	Implementation of Trust Guidelines						
-601	Operational Policy						Operational policy
-702	Data Collection (L2 & L3 PCC Units only)						Examples of data submitted. PICANet Annual Report
-703	Audit and Quality Improvement						Audit programme or plan. Examples of completed audits
-704	Key Performance Indicators						Recent monitoring reports
-705	Research (L3 PCC Units only)						
-706	Annual Report (L3 PCC Units only)						Annual Report
-798	Review and Learning						Documentation depends on local arrangements, for example, minutes or reports.
-799	Document Control						Compliance determined from other documentation presented.
ED- ADDITIONAL STANDARDS							
ED-211	ED Liaison Paediatrician						

QS Ref. No.	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
Ref.		BI	Visit	MP&S	CNR	DOC	
ED-212	ED Sub-speciality Trained Consultant	■					
ED-213	Small Emergency Departments	■		■			
ED-214	Trauma Team	■		■			
ED-403	Facilities for Children		■				
ED-510	Trauma Guidelines			■		■	Clinical guidelines
ED-511	Trauma Clinical Guidelines			■		■	Clinical guidelines
ED-512	Trauma Imaging Guidelines			■		■	Clinical guidelines
ED-602	Urgent Care Centres			■		■	Details of staff competences in paediatric resuscitation and life support. Recent rota Clinical guidelines or protocol
ED-603	Emergency Centres for Adults Only – Avoiding Child Attendances		■	■		■	Protocols
ED-701	Data Collection			■		■	Examples of data submitted
T- STANDARDS							
T-101	Information for Parents		■	■			
T-199	Involving Children and Families			■		■	Examples of changes made as a result of feedback
T-201	Lead Consultant/s and Lead Nurse/s	■		■			
T-202	Staff Authorised to Undertake Emergency Transfers			■		■	List of authorised staff
T-203	Service Competences and Training Plan			■		■	Competence framework describing the competences expected for roles within the service. Training and development plan to show how staff will achieve and maintain competences
T-204	Staffing Levels and Skill Mix			■		■	Recent rotas
T-205	Indemnity			■		■	Details of indemnity arrangements
T-299	Administrative, Clerical and Data Collection Support	■		■			

QS Ref. No.	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
Ref.		BI	Visit	MP&S	CNR	DOC	
T-401	Voice Communication						
T-402	Emergency Transport Arrangements						Specification or similar documentation
T-403	Equipment						
T-501	Referral Handling						Guidelines or policy
T-502	Service Guidelines						Guidelines or policy
T-601	Operational Policy						Operational policy
T-602	Operational Policy – Aeromedical Transport						Operational policy
T-701	Data Collection						Examples of data collected
T-702	Audit and Quality Improvement						Audit programme or plan. Examples of completed audits
T-703	Key Performance Indicators						Recent monitoring reports
T-704	Annual Report						Annual Report
T-798	Multi-disciplinary Review and Learning						Documentation depends on local arrangements, for example, minutes or reports.
T-799	Document Control						Compliance determined from other documentation presented.
A- STANDARDS							
A-101	Information on Anaesthesia						
A-199	Involving Children and Families						Examples of changes made as a result of feedback
A-201	Lead Anaesthetist						
A-202	Lead Anaesthetist for Paediatric Critical Care (PCC Units only)						
A-203	GICU Lead Consultant and Lead Nurse for Children						
A-204	On Site Anaesthetist						Recent rotas
A-205	Consultant Anaesthetist 24 Hour Cover						Recent rotas
A-206	Medical Staff Caring for Children						List of staff with details of paediatric resuscitation & life support competences

QS Ref. No.	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
Ref.		BI	Visit	MP&S	CNR	DOC	
A-207	Elective Anaesthesia						
A-208	Operating Department Assistance						List of staff with details of paediatric resuscitation & life support competences
A-209	Recovery Staff						
A-401	Induction and Recovery Areas						
A-403	Drugs and Equipment						
A-404	GICU Paediatric Area						
A-501	Role of Anaesthetic Service in Care of Critically Ill Children						Clinical guidelines
A-502	GICU Care of Children						Clinical guidelines
A-503	Clinical Guidelines - Anaesthesia						Clinical guidelines
A-598	Implementation of Trust Guidelines						
A-601	Liaison with Theatre Manager						
A-602	Children's Lists						
A-701	GICU Critical Care Minimum Data Set						Examples of data collected
A-798	Review and Learning						Documentation depends on local arrangements, for example, minutes or reports.
A-799	Document Control						Compliance determined from other documentation presented.
N- STANDARDS							
N-199	Involving Children and Families						Examples of changes made as a result of feedback
N-201	Network Lead Consultant and Lead Nurse						
N-202	Network Manager						
N-203	Educator						
N-204	Competence Framework						
N-205	Network Training Needs Analysis						Report with results of analysis
N-206	Network-wide Training and CPD Programme						Details of programme
N-299	Administrative, Clerical and Data Collection Support						
N-501	Patient Pathways						Agreed pathways

QS Ref. No.	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
Ref.		BI	Visit	MP&S	CNR	DOC	
N-502	Network Capacity Plan						Agreed plan
N-503	Network Guidance						Agreed guidance
N-601	Network Establishment and Operational Policy						Network establishment agreement or equivalent
N-602	Network Service Configuration						Agreed network configuration
N-701	Network Data Collection						Summary of network data collection
N-702	Network Audit						Agreed programme or plan. Examples of completed audits.
N-703	Network Quality Assurance						Details of network quality assurance programme
N-704	Network Annual Meeting and Annual Report						Notes of meeting. Network Annual Report
N-705	Network Risk Register						Network Risk Register
N-798	Network Multi-disciplinary Review and Learning						Documentation depends on local arrangements, for example, minutes or reports.
N-799	Network Document Control						Compliance determined from other documentation presented.
C- STANDARDS							
C-601	Paediatric Critical Care Needs Assessment and Strategy						Needs assessment and strategy
C-602	Commissioning: Urgent Care for Children						Description of services commissioned
C-603	Commissioning: Paediatric Critical Care						Description of services commissioned. Service specifications
C-604	Paediatric Critical Care Operational Delivery Network						Description of agreed network
C-701	Paediatric Critical Care Quality Monitoring						Recent monitoring reports

APPENDIX 5 CROSS- REFERENCES TO CARE QUALITY COMMISSION AND NHS LITIGATION AUTHORITY STANDARDS

The table below shows with an 'x' where a Quality Standard addresses one of the Care Quality Commission's Fundamental Standards and Key Questions (2014). The table also shows links between Quality Standards and NHSLA Risk Management Standards (2013/14).

Ref	CQC Five Key Questions
1	Are they safe?
2	Are they effective?
3	Are they responsive?
4	Are they caring?
5	Are they well-led?

Ref	CQC Fundamental Standards
9	Care and treatment must be appropriate and reflect service users' needs and preferences.
10	Service users must be treated with dignity and respect.
11	Care and treatment must only be provided with consent.
12	Care and treatment must be provided in a safe way.
13	Service users must be protected from abuse and improper treatment.
14	Service users' nutritional and hydration needs must be met.
14	All premises and equipment used must be clean, secure, suitable and used properly.
16	Complaints must be appropriately investigated and appropriate action taken in response.
17	Systems and processes must be established to ensure compliance with the fundamental standards.
18	Sufficient numbers of suitably qualified, competent, skilled and experienced staff must be deployed.
19	Persons employed must be of good character, have the necessary qualifications, skills and experience, and be able to perform the work for which they are employed (fit and proper persons requirement).
20	Registered persons must be open and transparent with service users about their care and treatment (the duty of candour).

More detail can be found at http://www.cqc.org.uk/content/our-fundamental-standards

	CQC Fundamental Standards												CQC Five Key Questions					NHSLA Risk Management Standards 2013/2014
Ref.	9	10	11	12	13	14	15	16	17	18	19	20	1	2	3	4	5	
HW- STANDARDS																		
HW-201									x	x	x	x	*	*	*		*	2.8
HW-202									x	x	x	x	*	*	*		*	1.9, 2.8, 3.1, 3.2, 3.4, 3.7, 3.8, 3.9, 4.3
HW-203									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.7, 3.8, 3.9, 4.3

	CQC Fundamental Standards												CQC Five Key Questions					NHSLA Risk Management Standards 2013/2014
Ref.	9	10	11	12	13	14	15	16	17	18	19	20	1	2	3	4	5	
HW-204									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.7, 3.8, 3.9, 4.3
HW-205									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.7, 3.8, 3.9, 4.3
HW-206									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.7, 3.8, 3.9, 4.3
HW-401							x		x				*	*	*			2.8, 4.1, 4.9, 5.4
HW-501			x	x					x				*	*	*	*	*	2.8, 4.1, 4.9
HW-502			x	x					x				*	*	*	*	*	2.8
HW-598			x	x					x				*	*	*	*	*	2.8
HW-602				x					x				*	*			*	2.8
ED-, CA-, IP-, L1-, L2- & L3- STANDARDS																		
-101				x			x		x				*	*				4.1
-102	x	x	x						x				*	*	*	*		2.8,5.1
-103	x	x	x						x				*	*	*	*		2.8,5.2
-104	x	x	x						x				*	*	*	*		2.8,5.2
-105		x					x		x				*	*	*	*		2.8, 4.1, 4.9, 5.4
-196	x	x	x	x									*	*	*	*		2.8, 5.2
-197	x	x	x	x					x				*	*	*	*	*	2.8, 2.10, 5.2
-199	x	x	x					x						*	*	*		2.3, 2.8, 2.10
-201										x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-202										x	x	x	x	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-203									x	x	x	x	x	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.1,5.3, 5.5
-204									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-205									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-206									x	x	x		*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-207									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5

	CQC Fundamental Standards												CQC Five Key Questions					NHSLA Risk Management Standards 2013/2014
Ref.	9	10	11	12	13	14	15	16	17	18	19	20	1	2	3	4	5	
-208									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-209									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-298									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
-299									x	x	x			*	*			3.1, 3.4, 3.7, 3.8
-301							x		x		x	x	*	*	*			5.4, 5.5, 5.6, 5.7
-302							x		x				*	*	*		*	,4.8, 5.4, 5.5
-401							x		x				*	*	*		*	5.4, 5.5
-402							x		x				*	*	*		*	5.4, 5.5
-404							x		x				*	*	*		*	5.4, 5.5
-405							x		x				*	*	*		*	5.4, 5.5
-406							x		x				*	*	*		*	5.4, 5.5
-501				x					x				*	*	*	*		2.8
-502				x					x				*	*	*	*		2.8, 4.8
-503				x					x				*	*	*	*		2.8, 4.8
-504				x					x				*	*	*	*		2.8, 4.8, 4.9
-505				x					x				*	*	*	*		2.8, 4.8,
-506				x					x				*	*	*	*		2.8, 4.8,4.9
-507				x					x				*	*	*		*	2.8, 4.8,4.9
-508				**x**					**x**				*	*	*		*	2.8, 4.8,4.9
-509				**x**					**x**				*	*	*		*	2.8, 4.8,4.9
-598									**x**				*	*	*		*	2.8, 4.8,4.9
-601				**x**					**x**				*	*	*		*	1.7, 1.8, 2.8, 2.10, 4.9, 4.10, 5.3, 5.5
-702				**x**					**x**			**x**	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
-703									**x**			**x**	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
-704									**x**			**x**	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
-705									**x**			**x**	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
-706									**x**				*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
-798									**x**			**x**	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
-799				**x**					**x**				*	*				1.2
ED- ADDITIONAL STANDARDS																		

	CQC Fundamental Standards												CQC Five Key Questions					NHSLA Risk Management Standards 2013/2014
Ref.	9	10	11	12	13	14	15	16	17	18	19	20	1	2	3	4	5	
ED-211									x		x	*	*	*	*	*	x	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
ED-212									x	x	x	x	x	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
ED-213									x	x	x	x	x	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, , 5.3, 5.5
ED-214									x	x	x	x	x	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
ED-403							x		x				*	*	*		*	5.4, 5.5
ED-510				x					x				*	*	*		*	2.8, 4.8,4.9
ED-511				x					x				*	*	*		*	2.8, 4.8,4.9
ED-512				x					x				*	*	*		*	2.8, 5.7
ED-602				x			x		x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7,4.1, 4.5, 4.8, 4.9,5.3, 5.5
ED-603				x					x				*	*	*	*	*	2.8, 4.8, 4.9
ED-701				x					x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
T- STANDARDS																		
T-101	x	x	x						x				*	*	*	*		2.8,5.2
T-199	x	x	x					x	x					*	*	*		2.3, 2.8, 2.10
T-201									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
T-202									x	x	x		*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
T-203									x	x	x		*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
T-204									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
T-205									x	x	x		*	*	*		*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
T-299									x	x	x			*	*			3.1, 3.4, 3.7, 3.8
T-401							x		x				*	*	*		*	5.4, 5.5
T-402				x			x		x				*	*	*		*	4.1, 4.2 5.4, 5.5
T-403				x			x		x				*	*	*		*	5.4, 5.5

	CQC Fundamental Standards												CQC Five Key Questions					NHSLA Risk Management Standards 2013/2014
Ref.	9	10	11	12	13	14	15	16	17	18	19	20	1	2	3	4	5	
T-501				x					x									2.8, 4.1, 4.2
T-502									x									4.5, 5.4, 5.5
T-601				x					x				*	*	*		*	1.7, 1.8, 2.8, 2.10, 4.9, 4.10, 5.3, 5.5
T-602				x					x				*	*	*		*	1.7, 1.8, 2.8, 2.10, 4.9, 4.10, 5.3, 5.5
T-701				x					x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
T-702				x					x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
T-703									x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
T-704									x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
T-798									x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
T-799				x					x				*	*				1.2
A- STANDARDS																		
A-101	x	x	x	x					x				*	*	*	*		2.8, 5.2
A-199	x	x	x					x	x					*	*	*		2.3, 2.8, 2.10
A-201									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-202									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-203									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-204									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-205									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-206									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-207									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-208									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5

	CQC Fundamental Standards												CQC Five Key Questions					NHSLA Risk Management Standards 2013/2014
Ref.	9	10	11	12	13	14	15	16	17	18	19	20	1	2	3	4	5	
A-209									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
A-401				x			x		x				*	*	*		*	5.4, 5.5
A-403							x		x				*	*	*		*	5.4, 5.5
A-404				x			x		x				*	*	*		*	5.4, 5.5
A-501				x					x				*	*	*		*	2.8, 4.8,4.9
A-502				x					x				*	*	*		*	2.8, 4.8,4.9
A-503				x					x				*	*	*		*	2.8, 4.8,4.9
A-598				x					x				*	*	*		*	2.8, 4.8,4.9,5.2
A-601				x					x				*	*	*		*	2.8, 3.5
A-602				x					x				*	*	*		*	2.8
A-701				x					x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
A-798									x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8,2.10
A-799				x					x				*	*				1.2
N- STANDARDS																		
N-199	x	x	x					x	x					*	*	*		2.3, 2.8, 2.10
N-201									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
N-202									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
N-203									x	x	x	x	*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
N-204									x	x	x		*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
N-205									x	x	x		*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.5,3.6, 3.7, 4.5, 5.3, 5.5
N-206									x	x	x		*	*	*	*	*	1.9, 2.8, 3.1, 3.2, 3.4, 3.6, 3.7, 4.5, 5.3, 5.5
N-299									x	x	x		*	*	*	*		3.1, 3.4, 3.7, 3.8
N-501				x					x				*	*	*		*	2.8
N-502				x					x				*	*	*		*	2.8, 4.8,4.9
N-503				x					x				*	*	*		*	2.8, 4.8,4.9
N-601				x					x				*	*	*		*	1.7, 1.8, 2.8, 2.10, 4.9, 4.10, 5.3, 5.5

	CQC Fundamental Standards												CQC Five Key Questions					NHSLA Risk Management Standards 2013/2014
Ref.	9	10	11	12	13	14	15	16	17	18	19	20	1	2	3	4	5	
N-602				x					x				*	*	*		*	2.8
N-701				x				x	x			x	*	*	*		*	2.1, 2.2, 2.6, 2.8
N-702				x					x			x	*	*	*		*	2.1, 2.2, 2.6, 2.8
N-703				x					x			x	*	*	*		*	2.1, 2.2, 2.6, 2.8
N-704				x					x				*	*	*		*	2.1, 2.2, 2.6, 2.8
N-705				x					x				*	*	*			1.4
N-798									x			x	*	*	*		*	2.1, 2.2, 2.6,2.7 2.8, 2.10
N-799				x					x				*	*				1.2
C- STANDARDS																		
C-601				x					x				*	*	*	*	*	2.8
C-602				x					x				*	*	*	*	*	2.8
C-603				x					x				*	*	*	*	*	2.8
C-604				x					x				*	*	*	*	*	2.8
C-701				x					x				*	*	*	*	*	2.1, 2.2, 2.6, 2.8,2.10