Worcestershire Acute Hospitals NHS Trust

Operational Policy for Childrens day surgery at Kidderminster Treatment Centre

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Key Documents Owner:	Dr Gallagher	Consultant Paediatrician
Approved by:	Paediatric Quality Improvement meeting	
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Key Amendments

Date	Amendment	Approved by
March 2014	New document	
March 2016	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
January 2018	All day CYP day case surgery piloted and now implemented	

Introduction

Day surgery is particularly appropriate for children, provided the operation is not complex or prolonged and the child is well with either no or only mild well controlled co-morbidity. Even children with relatively complex needs, for example cerebral palsy, cystic fibrosis, can be managed as day cases provided they are stable with minimal cardio-respiratory problems, and surgery is minor.

Standards for Children's Surgery, produced by Children's Surgical Forum (2013) explain children should be treated on dedicated lists, or at the very least, the first part of lists and separated from adults. They should be nursed in paediatric areas, with Registered Children's Nurses and have play facilities available. Day surgery should be provided for children whenever practical, with a named consultant surgeon responsible for care. As with inpatient surgery, a named consultant paediatrician should be available for liaison and immediate advice and cover, and outcomes should be audited and reviewed. This applies to the time when children may be present on hospital sites providing day surgery only. When day surgery is undertaken in a centre without inpatient paediatrics, a neighbouring children's service must take formal responsibility for the children being managed in the unit, and there should be a clear plan for transfer should this be necessary (appendix 1).

Kidderminster Treatment Centre has a self-contained day surgery unit, with its own admission suite, theatre and recovery area. With some adaption to achieve a CYP friendly environment; this lends itself to become a suitable environment for undertaking elective day surgery for children and young people. Day surgery is scheduled on dedicated children's theatre lists.

Purpose

This operational policy articulates how children's day surgery at Kidderminster Treatment Centre is planned, delivered and quality assured.

Scope

Includes

The scope of this policy includes children's services delivered via the Children's Directorate, Theatre Services and the Surgical Services delivered via the Surgical Division. This includes nursing, theatre, medical and allied health care professionals.

This policy demonstrates compliance with the standards outlined in Standards for Children Surgery (CSF, 2013) (appendix 1) and the WMQRS Care of the critically I'll and Injured Children Quality Standards (December 2016) (appendix 2).

The policy is divided into two sections. Section 1 outlines the scope of the Children's Day Surgery Service and Section 2 outlines the CYP patient flow through the Service i.e:

- Pre-Assessment
- Admission
- Recovery
- Discharge

Supportive information can be found in the Appendices.

A parent can expect to be with their child during treatment, including induction of anaesthesia and awakening, unless it puts either the parent or the CYP at risk. Clear and concise information is given to the parents and CYP to enable them to take part in all decisions about treatment and aftercare. Parents and CYP are advised of the advantages, disadvantages, risks, side effects and alternative treatments. Verbal information is supported with printed information where possible. Interpreting services can be arranged for those whose first language is not English.

Excludes

See 5.1.3 for exclusions criteria.

Definitions

Child/Young Person (CYP) – 2-17 year old
Parent – Parent or main carer
RN (C) – Registered Children's Nurse
ENT – Ear, Nose and Throat
Open access – able to contact ward directly and return to Riverbank Unit at Worcestershire Royal Hospital if necessary

Duties

Duties within the Organisation

The Children's Directorate Management Team is comprised of the Children's Clinical Director, Head of Nursing for CYP, Directorate Manager and Matron for CYP. The management team are individually and collectively responsible for the maintenance, implementation and review of this policy on an annual basis in line with the business planning cycle.

Identification of Stakeholders

- All staff, clinical and non-clinical, within the Children's Directorate
- All specialisms taking care of children and young people on the Kidderminster site; clinical, nursing, medical and service managers (Surgeons, Theatre staff).

Duties within KTC

Statement of function

Children's Day Surgery will take place for the full day on Wednesday weeks 1, 3 and 5 and will consist of a mixture of ENT, Urology General Surgery, Orthopaedics, Ophthalmology, Oral facial surgery and Community Dental lists.

The surgery will be undertaken by Consultant Surgeons supported by Consultant Anaesthetists with a paediatric interest, plus associated theatre staff. The team will be supported by children's nurses (one of whom will be an EPLS provider) who will assess and admit the child and care for the child during second stage recovery and discharge. A Paediatric Consultant will be available in the Children's Outpatient Clinic. A designated Consultant Anaesthetist and Consultant Paediatrician will remain on site until the last child is discharged from the unit. Once surgeons have reviewed their patients post-op and written a plan in the notes they will be available for immediate advice or to liaise with their on-call colleagues at WRH if a CYP needs admitting. They will be available to return to KTC within 30 minutes to review their patients.

During the afternoon the children's clinic at Kidderminster Treatment Centre will carry out pre-operative assessment of children for the following week's theatre list; the children on the community dental lists will also have telephone pre-operative assessment.

The accommodation and facilities required to support the theatre list consist of:

- Reception area and waiting area with seating for children and families.
- 5 cubicles for the assessment of children by the children's nurses, consultant surgeon and anaesthetist pre-operatively.
- Changing area (into theatre gowns if required)
- Anaesthetic Room
- Theatre
- First Stage Recovery
- Discharge Lounge (formerly known as Second Stage Recovery)
- Discharge Lounge – seated area

Workload

There is an average attendance of 38-40 patients each Wednesday Paediatric session:

Exclusions

- Children under the age of 2 years (Please refer to WAHT Guidelines for paediatric general surgery and WAHT Guidelines for Operating on ENT patients, children and young people). Children having Tonsillectomy must weigh more than 15kg. (separate national guidance)
- Children likely to require overnight stay
- Children with underlying pathology which may require medical intervention

Hours of operation

Wednesdays, weeks 1, 3 and 5
07.30 to 18.00 hours

Staffing, Role and Responsibilities

Management Team

The management team includes:

Clinical Director (CD):

The CD is responsible and accountable for the delivery of services within the Children's Directorate. The CD is expected to ensure all activities undertaken within the directorate are subject to robust operational, clinical and financial governance arrangements with patient safety, quality and clinical outcomes at the centre of all aspects of operational management.

Head of Nursing (HON):

The HON is responsible and accountable for the delivery of high quality, safe care whilst enhancing patient experience across the services provided by the directorate. The HON is responsible for the management of all children's nursing and support staff whilst promoting safe and effective clinical practice within the Children's Directorate.

Directorate Manager (DM):

The DM is responsible for working with the CD and HON to ensure that robust performance management; planning and governance mechanisms are in place in line with the Trusts policies and best practice. The DM is responsible for ensuring all planning is in line with the Trusts strategic direction and that performance is reported monthly to the Performance Board.

Matron (M):

The Matron is responsible for the day to day operational delivery of services within the Children's Directorate ensuring Children receive the right care in the right place. The Matron is also responsible for monitoring and maintaining safe staffing levels and assessing and mentoring staff to constantly strengthen clinical practice.

Medical

Each medical staff is allocated per theatre list and this includes:

Consultant Surgeon

The consultant surgeon is responsible for seeing all CYP undergoing surgery on the day of operation.

The surgeon is responsible for reviewing the CYP and determine whether the surgical procedure remains appropriate, ensure that the CYP and parents understand the surgical procedure, risks and benefits of the procedure to enable signed informed consent and ensure that the CYP and parent are knowledgeable about the CYP's treatment, discharge advice and follow up required.

Consultant Anaesthetist

The consultant anaesthetist is responsible for seeing all CYP having surgery under general anaesthetic on the day of the operation. The anaesthetist is responsible for establishing the child's health status, identify any potential problems, airway assessment, discuss anaesthetic technique, provide post-operative instructions, discuss analgesia and pain management and give the CYP and parent an opportunity to ask questions so that they can give informed consent.

Consultant Paediatrician

Available on site for the whole time CYP are in the operating department for liaison and immediate advice and cover, for example in cases of children requiring on-going care following resuscitation, and to advise on safeguarding issues.

Children's Nursing

The current complement of nursing staff of which 1 nurse holds EPLS:

Role	WTE	Headcount
RN Child /RSCN	1.68	6
HCA	0.3	1
Play Team	0.3	1
TOTAL	**2.28**	**8**

RN Child / RSCN

All staff assessing and treating children and young people maintain competencies in the recognition of a critically ill or deteriorating child, implementing resuscitation and alerting the appropriate staff in a timely and effective manner.

At least one nurse per shift will be trained in paediatric advanced life support training (APLS/EPLS or equivalent).

Staff caring for children are competent in assessment of pain (verbal and non-verbal) and use of pain assessment tools suitable for the age and development of child.

Staff caring for children will have received Level 3 training in safeguarding children as part of their mandatory training.

Governance and Quality

Co-ordinate the systems, policies and processes and most of the external communication with organisations such as the CQC and Clinical Commissioning Groups in the following areas:

Registration with the CQC and coordination of inspections:

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- Registration with the CQC and coordination of inspections
- Quality review visit programme - coordination
- Risk Management - risk assessment and risk registers
- Patient Safety - incident reporting, investigation and training
- Mortality Review system and process coordination
- Patient Safety Alerts - coordination of responses
- Datix - System management, development, training
- Clinical Audit - coordination of Divisional forward plans, assisting and advising in the design, analysis and reporting of clinical audit

- Key document management
- NICE Guidance - coordinating the receipt, review and on-going assurance of compliance with National Guidance

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Clinical Risk and Safety

The Children's Directorate strives to minimize risks and maximize the quality of service to children and young people who come under its care. The management of risk is an integral part of the Directorate's everyday business. Senior team members are responsible for fostering an environment whereby all staff are encouraged to report incidents and near misses, which feeds into our learning and continuous improvement through the directorate Clinical Improvement Meeting and Divisional Governance Board.

Incident reporting and investigations

The mechanism for reporting incidents is the Trust on line Datix system. Incidents are investigated by the local incident managers for each clinical area to establish trends or recurrent patterns of incidents and reported to the Divisional Governance Board monthly. Learning from incidents is shared via the monthly Effective Handover and daily safety huddles. Where actual or potential harm occurs, a more urgent action is needed.

Risk management

Clinical risks are identified through the incident investigation reports. Recognised risks which are not able to be addressed readily are placed on the Trust's Risk Register.

Guidelines

The Children's Directorate has adopted the 2013 guidelines that cover aspects of patient care for surgery. All guidelines can be found on the Trust Intranet and are listed alphabetically under sub-headings.

Network guidelines are updated every 3 years.

Once approved guidelines are uploaded to the Intranet. Internal guidelines are updated every 3 years.

Education & Training Requirements

- Medical staff can access study leave
- Middle grade / SHOs have protected reading time
- Nursing Staff undertake Mandatory study days (including Resuscitation and Safeguarding CYP – Level 3) and continuing professional development. Other study time and funding by negotiation, in conjunction with the department Training Plan and the individual's PDP.
- Theatre Staff – Mandatory Study Days and professional update days. PILS and Safeguarding CYP Level 2 training.

- Support Workers – Mandatory study days and some study days funded by the Trust. NVQ training possible

Interdepartmental relationships/specialist and support services
Clinical

Theatre	Transfer of children for routine and emergency surgical procedures
Radiology	Transfer of children to X-ray department for investigations
Microbiology	Transfer of specimens for analysis
Haematology	Transfer of specimens for analysis
Biochemistry	Transfer of specimens for analysis
Pharmacy	For top-up of stock items as well as preparation of drugs for children to take home. Regular liaison with Paediatric link pharmacist (based at the Worcestershire Royal Hospital) to ensure drug related procedures are up to date
Children's Community Nurses (Orchard)	To promote early discharge and prevent unnecessary admissions to hospital

Non-clinical

Security	Re: visitor access, missing children, child abduction (risk management)
Catering	To ensure suitable nutrition is available to children and breast-feeding mothers
Housekeeping	To ensure high standards of tidiness and cleanliness are maintained

Community

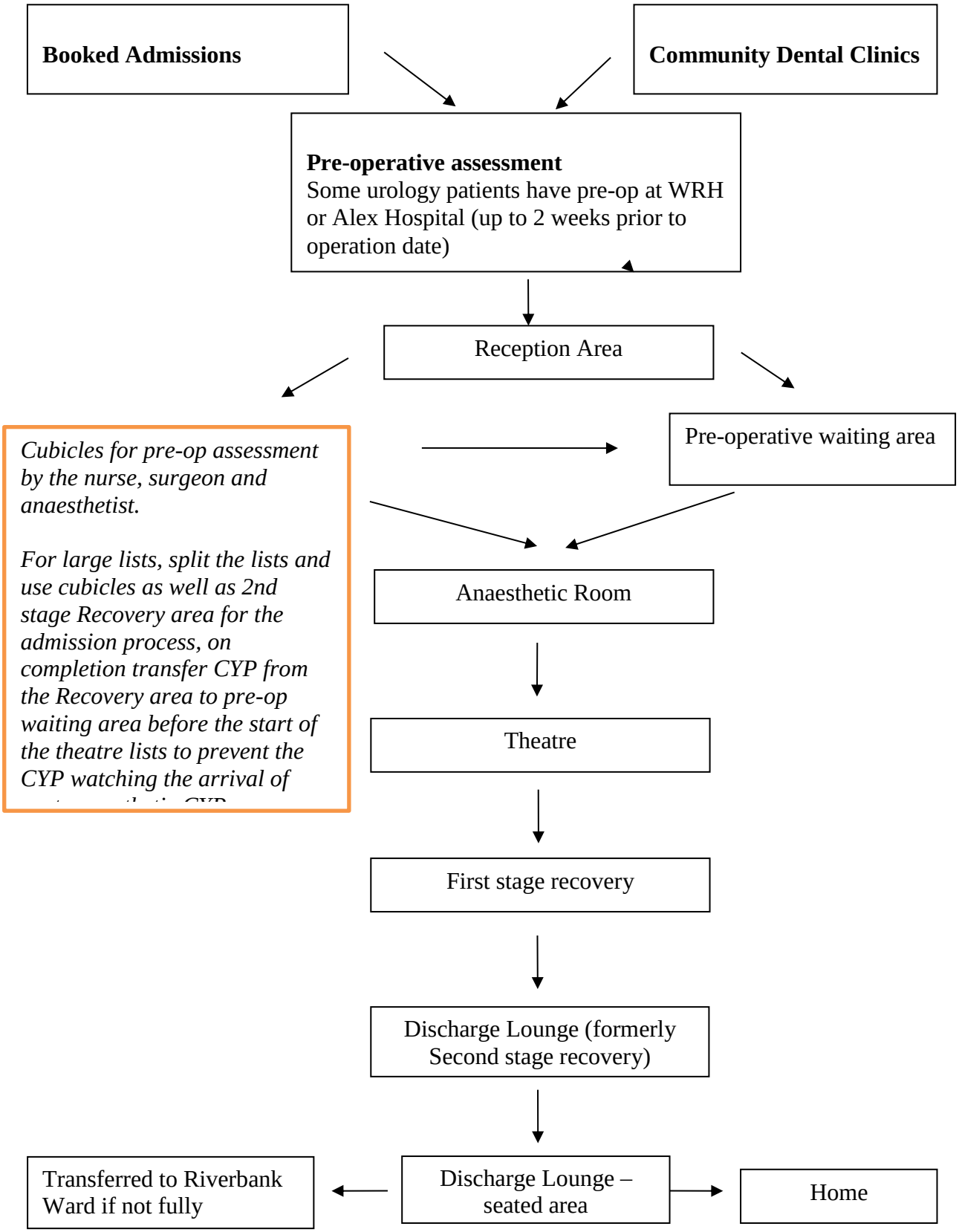
- General Practitioners
- Health Visitors
- Practice Nurses
- School Nurses
- Children's Services
- Child Protection Officer
- Paediatric liaison Health Visitor

Clinical and non-clinical Equipment / Information Technology

Please refer to Appendix 3 for full list of paediatric equipment and storage areas

Resuscitation Equipment – to be checked prior to commencement of the CYP Day Surgery lists.

CYP PATIENT FLOW



Pre-Operative Assessment

The Pre-operative Assessment Clinic is nurse-led and is an opportunity to:

- Identify who has parental responsibility for consent and safeguarding purposes, so that they are able to take part in all decisions about treatment and aftercare and be advised of the advantages and disadvantages, risks, side effects of treatment.
- Explain to CYP and their parents the day surgery pathway.
- Impart information regarding planned procedures and postoperative care to help CYP and their parents make informed decisions – provision of important information should be supported in writing.
- Identify medical risk factors and suitability for day surgery
- Consider the need to contact other disciplines/supporting agencies who are already involved in the child's care, to inform them of the child's admission and involve them in plans for discharge home.
- Consider the family's need for involvement of these disciplines, where there has been no previous support.
- Explore family circumstances and background in the context of planning for discharge and ensuring that appropriate support is in place.
- If not already in place, interpreting services can be arranged for those whose first language is not English. This can either be using verbal translation, face-to face interpreting or telephone interpreting. Details are held on the Trust's intranet Services A-Z 'Interpreting Services'

Preparation for discharge home should begin at the time the CYP attends the pre-operative assessment clinic, undertakes telephone pre-assessment or is admitted for surgery.

The CYP will be assessed by a Registered Children's Nurse and the 'Paediatric Anaesthetic Pre-Assessment Questionnaire' will be completed. Any concerns identified which impacts on the suitability for the CYP attending Day Surgery at Kidderminster Treatment Centre will be discussed with the Anaesthetist before decision to admit is finalized.

Telephone Pre-Assessment can be offered for those CYP who are unable to attend the pre-admission clinic.

At the pre-admission clinic appointment, the child and parent must be given information (using various mediums) regarding the:

- Date and time of admission to the unit.
- Location of the unit and travel instructions (including parking)
- Details of the surgery to be undertaken, expected length of stay and any relevant pre-operative preparations required for the CYP.
- Information on the anaesthetic to be provided, including clear instruction for pre-operative fasting, and the way in which the parent will manage the CYP medication if appropriate.
- Post-operative discharge information, including details of follow up appointments, management of drugs, pain relief and dressings, and clear instruction on whom to contact in the event of post-operative problems.
- Parent must also be made aware at the pre-admission visit that conversion to inpatient care is always a possibility and that in the unlikely event that they are not ready to go

home on the day of the operation they will be cared for overnight. The CYP will be accommodated along with their parent on Riverbank at Worcestershire Royal Hospital.

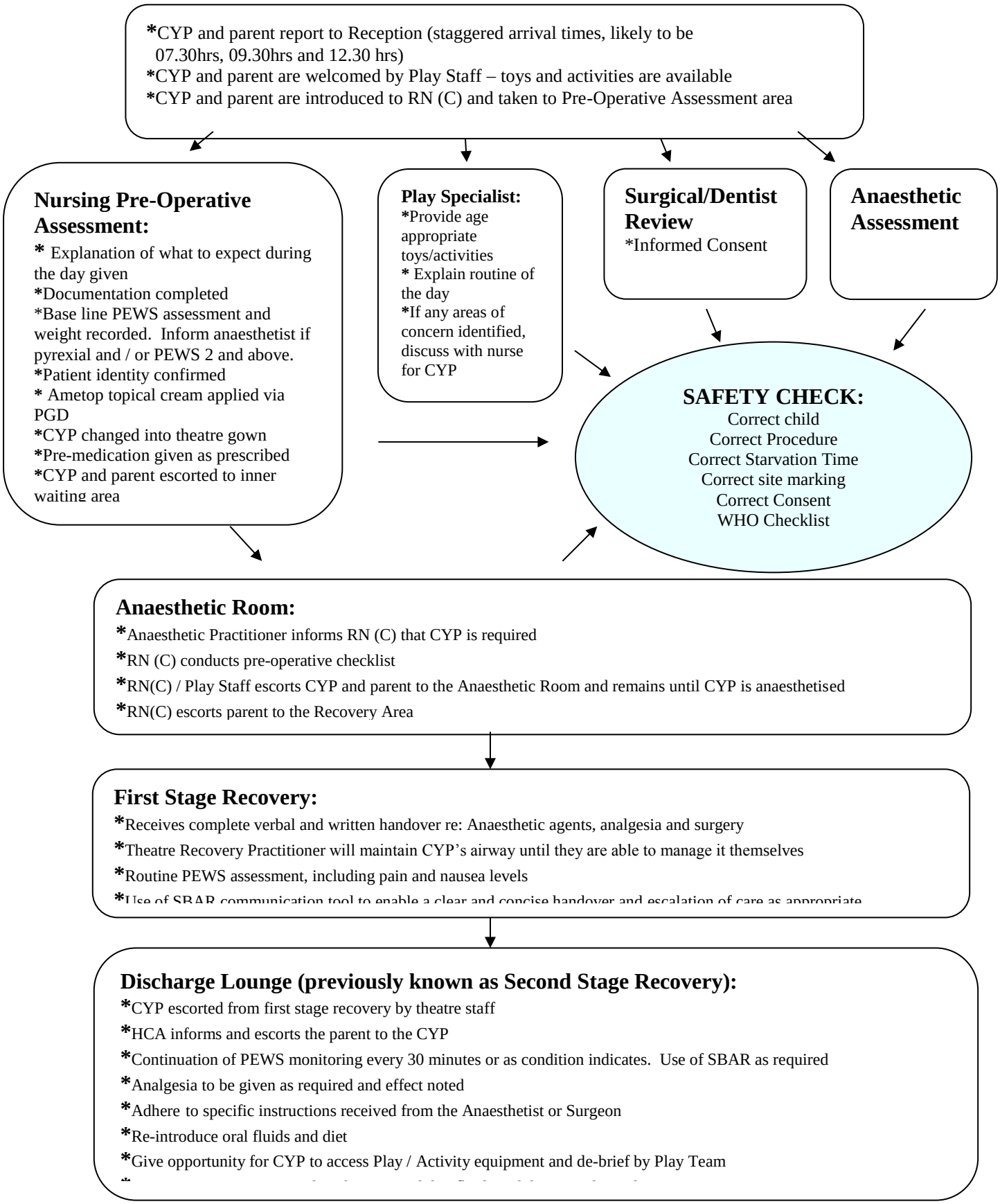
- Parent must be advised that two responsible adults need to attend with the CYP on the day of operation, one of whom must have parental responsibility. Two adults are required in order to maintain the CYP's safety on the journey home as public transport is not advised.
- Parents to be made aware that they should inform the team of any changes in the CYP health status during the interim period before surgery and bring any relevant patient held health records / information with them (such as the 'red book').
- Young females (aged 13 years and above) and have started menarche should be made aware of the need for clinicians to establish pregnancy status before surgery or procedures involving anaesthesia and Fraser Guidelines should be incorporated in this process. Where appropriate, this will generally result in relevant confidential questioning at pre-operative assessment (where possible) and on admission. At this discussion issues around confidentiality and nursing responsibility will be made clear. Questions around possibility of pregnancy and periods should be direct and using language the young person can understand. Please refer to Appendix 4: Pre-procedural Pregnancy Testing for under 16-year olds (RCPCH Guidance, 2012) for further guidance. Should pregnancy testing be undertaken and indicates a positive result, always consider the need for safeguarding and ongoing support.

The CYP and parent will speak to a member of the Play Team, who will help to:

- Reduce anxiety and uncertainty through the provision of age appropriate information.
- Acknowledge and address specific concerns.
- Enable CYP to understand, at a developmentally appropriate level, the procedure they are to experience.
- Maximise coping strategies for the CYP.
- Enable CYP to participate in the consent process.
- Advise the parent how to help prepare their child for surgery, whilst they are at home.

ADMISSION

PATIENT FLOW



In case of an emergency/transfer

A dedicated paediatric emergency team will be available and can be contacted using the '**2222**' emergency number. For further information please refer to Kidderminster Site Emergency Response Protocol (WAHT-CG-025).

This team will lead the resuscitation supported by the site team:

Paediatric anaesthetist	In Theatres
Paediatrician	Bleep No. 3110

Please refer to Paediatric Resuscitation, Stabilisation, Retrieval and Transfer Guideline (WAHT-ANA-009) for further information.

Should further intervention be required contact KIDS (Kids Intensive Care and Decision Support) on 0300 200 1100

KIDS Referral form is available on the Intranet under 'Paediatrics/Paediatric Guidelines.

Age appropriate PEWS (Paediatric Early Warning Score) and SBAR (Situation, Background, Assessment and Recommendation) Communication Tool will be used in order to ensure a shared understanding of concerns and enable actions to be communicated and documented clearly.

Admissions Area
The nursing and support staff are expected to arrive in the department at 07.30 hrs. They will then set up the Admission, Recovery and Discharge area to make it a suitable and safe environment for CYP (please see Appendix 2) for list of equipment and storage areas. Safety checks for emergency equipment: oxygen, suction, resuscitation equipment etc. must be completed before CYP theatre lists commence. Check that a Consultant Paediatrician is onsite in the Children's Clinic; on the rare occasion that one is not available (e.g. short notice sickness) check what contingency plan has been put in place and whether this is appropriate.

Children and young people, along with their parents and carers, should be involved in all aspects of their care whenever possible. The CYP and parents should have an opportunity to ask questions of the surgeons, anaesthetists, nurses and play team so that they are able to give informed consent.

The CYP must be accompanied by a parent / carer who have parental responsibility in order for them to give legal consent. The Department of Health stipulates that consent should be obtained by a clinician who is capable of performing the procedure or has had specialist training in giving advice about the procedure (DoH 2009). Consent will be obtained by the Consultant Surgeon undertaking the procedure, using Consent Form 1 for adults or competent CYP and Consent Form 2 for parental consent for a child or young person. (Please refer to Policy for consent to examination or treatment WAHT-CG-075 for further information)**.**

On arrival to the department the CYP and parent need to be orientated to the area and an explanation given on how the day is expected to proceed. The CYP and parents will be seen by the:

- Nurse / Play Team
- Surgeon
- Anaesthetist

Nurse:

Commence the Theatre Safety Check List consisting of:

- Correct child
- Correct Procedure
- Correct Starvation Time
- Correct site marking
- Correct Consent

Ask the CYP, if they are old enough, what they understand about why they have come to hospital. Correct any misunderstandings and encourage the CYP to ask questions or raise concerns. Liaise with the Play Team regarding preparation and distraction play/activities.

The CYP and parent will be asked to remain in the waiting room until it is time for their operation. The Play staff will be available to provide suitable toys and activities or work with the CYP to allay any concerns raised during the admission process.

The CYP and parent will be called into the Anaesthetic Room by the Nurse / Play staff and the Anaesthetic Nurse after re-checking the theatre safety checklist together with the CYP and parent.

Anaesthetic Room
The Anaesthetic Room will have undertaken their emergency checks and will be prepared to receive the CYP and parent. Appropriate sized equipment and medications will be prepared ready for use.

The staff will:

- welcome CYP and parent and make them comfortable in the Anaesthetic Room
- will check the patient theatre safety checklist with the Nurses and CYP and parent
- encourage the parent to comfort and talk to the CYP
- attach the required patient monitoring equipment
- carry out induction method agreed during pre-assessment / admission period
- encourage the parent to briefly say farewell when the child has fallen asleep, before leaving the Anaesthetic Room
- transfer the CYP to the operating theatre for the operation to take place.

First Stage Recovery
In the period immediately after anaesthesia the child will be managed in a recovery ward on a one to one basis by designated staff with up-to-date paediatric PILS competencies. There should never be fewer than two staff in the First Stage Recovery area.

The staff will:

- establish the identity of the CYP with the transferring staff
- receive a complete verbal and written handover re: Anaesthetic agents, analgesia and surgery
- Theatre Recovery Practitioner will maintain CYP's airway until they are able to manage it themselves
- routine PEWS assessment, including pain and nausea levels recorded at 5-minute intervals until transferred to Discharge Lounge

- use SBAR communication tool to enable a clear and concise handover and escalation of care as appropriate
- manage pain / nausea symptoms if exhibited
- check for any haemorrhaging or other possible adverse effects of surgery and anaesthesia.

When the CYP is able to maintain their own airway and is oriented they will be transferred to the Discharge Lounge (formerly known as second stage recovery).

Discharge Lounge

The Discharge Lounge (previously known as secondary recovery area) provides essential close and continued supervision of all CYP and is visible to the nursing staff.

The HCA will escort the parent to the CYP on their transfer to this area. The parent can remain with the CYP throughout this period and will be given an update on the condition of their child.

CYP in Discharge Lounge are cared for on trolleys; should this prove uncomfortable / distressing for the CYP and their condition allows a recliner chair can be brought into this area for their use.

The nursing staff will:

- continue PEWS monitoring every 30 minutes or as condition indicates. Any concerns or PEWS score of 3 and above will be escalated using SBAR communication tool
- pain assessment will be completed with PEWS monitoring and analgesia will be given as required and effect noted
- adhere to specific instructions received from the Anaesthetist or Surgeon
- re-introduce oral fluids and diet
- give opportunity for CYP to access Play / Activity equipment and de-brief by Play Team
- remove intravenous cannula, when assured that fluids and diet are tolerated
- when CYP is ready, they can dress in their own clothes and be escorted to the seating area in the adjacent Discharge Lounge.

Discharge

The CYP and parent will spend a period of time in the seating area of the Discharge Lounge to ensure that the CYP and parents are comfortable and confident for discharge from the department.

The nursing staff will ensure that:

- Intravenous cannula has been removed and that the CYP and parents are in possession of appropriate dressings that are necessary.
- All CYP and parents receive verbal and written instructions on discharge and be warned of any symptoms that might be experienced.
- All CYP are discharged with a supply of appropriate analgesics and instructions in their use will be given to the parents and CYP as appropriate. CYP must be pain free or at worst at minimal tolerable level prior to discharge.
- An explanation and leaflet will be given re: Open Access – a period of 24 hours post discharge in which the parents are able to contact Riverbank, Worcestershire Royal Hospital

and seek advice. If it is felt that attendance to the ward is required, the CYP would attend the ward directly, negating the need for referral from the GP or attendance at the Emergency Department.

- An email will be sent to Riverbank ward regarding the attending CYP to ensure they have up to date details for open access queries. Email address is: wah-tr.riverbank.ward@nhs.net
- A paper copy of the discharge summary or an electronic discharge summary, including nursing Discharge Summary will be completed, a copy of which will be given to the parents, copies sent to the GP and the Health Visitor/School Nurse, and a copy is retained in the CYP medical record. Details will be included of any follow-up appointments required and time of administration of analgesics given whilst in the department.
- CYP is appropriately dressed for discharged home and has two adults in attendance to ensure safe transport home.
- The parent has access to a telephone.
- Should CYP / parent take self-discharge against medical advice, please refer to Appendix 5.
- If CYP is unable to be discharged home they will be transferred via hospital transport, with their parent, to the inpatient Children's Ward at Worcestershire Royal Hospital. WMAS have agreed to provide an ambulance within 2 hours from initial request. Please refer to Appendix 6 re: transport arrangements.
- Offer CYP and parents a Friend and Family feedback form to give them the opportunity to comment on the care and the service they have received.

Appendices

Appendix 1

DAY SURGERY: Standards for Children's Surgery, Children's Surgical Forum (2013)

Endorsed by: The Association of Paediatric Anaesthetists of Great Britain and Ireland; The Association of Surgeons of Great Britain and Ireland**;** The British Association of Paediatric Surgeons**;** The British Association for Paediatric Otorhinolaryngology**;** The British Association of Paediatric Urologists**;** The British Association of Urological Surgeons**;** The British Orthopaedic Association**;** ENT UK**;** The Patient Liaison Group at the Royal College of Surgeons of England; The Royal College of Anaesthetists; The Royal College of Nursing; The Royal College of Obstetricians and Gynaecologists; The Royal College of Paediatrics and Child Health; The Royal College of Surgeons of England; The Society for Cardiothoracic Surgery in Great Britain and Ireland

No	Standard	Measurement Criteria
10.23	Children's surgery is provided on a daycase basis wherever practical.	▸▸ Example day case lists. ▸▸ Regular audit.
10.24	A named consultant surgeon is responsible for the care of the child but can delegate to other grades as appropriate.	▸▸ Named consultant responsible for each case. ▸▸ Regular audit.
10.25	A paediatric-trained consultant anaesthetist is present for day-case surgery but can delegate to other grades as appropriate.	▸▸ Copies of rotas
10.26	Parents and carers are given clear instructions on follow–up and arrangements in the case of postoperative emergency.	▸▸ Copies of information
10.27	A minimum of two registered children's nurses are present in day surgical areas	▸▸ Copies of rotas.
10.28	The outcomes of day-case activity is audited and reviewed.	▸▸ Regular audit and review
10.29	Processes are in place to facilitate transfer within the network should complications arise	▸▸ Description of process.

The following additional standards apply to centres undertaking day-case paediatric surgery **without inpatient paediatrics:**

No	Standard	Measurement Criteria
10.30	Elective surgery and anaesthesia is only delivered by consultant surgeons and anaesthetists experienced in the condition.	▸▸ Example rotas.
10.31	The surgeon and anaesthetist remain in the hospital until arrangements have been made for the discharge (or transfer) of all patients under their care. (WAHT note KTC is a stand alone / sateliite unit).	▸▸ Monitored on a ward-by-ward basis.
10.32	At least one member of the team has current advanced paediatric life support training. All team members have up-to-date basic skills for paediatric resuscitation.	▸▸ Appraisal. ▸▸ Evidence of training. ▸▸ Examples of rotas.
10.33	At least one member of the team with up to date basic skills for paediatric resuscitation is present throughout the period the child is in the unit.	▸▸ Example rotas
1034	A neighbouring children's service takes formal responsibility for the children being managed in the unit. Every effort is made to ensure this neighbouring unit is geographically close enough to ensure support is practical.	▸▸ Formal agreement in place.
10.35	Agreed and robust arrangements are in place for paediatric assistance and transfer if required.	▸▸ Formal arrangements in place and widely known.

Appendix 2

WMQRS Quality Standards for Care of Critically Ill and Critically Injured Child (December 2016) - Paediatric Anaesthesia Section and General (Adult) Intensive Care (GICU) standards)

Ref Number	Demo of compliance	Quality Standards	Notes on Quality Standards
PG-101	Visit MP&S	**Information on Anaesthesia** Age-appropriate information about anaesthesia should be available for children and families.	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).
PG-199	MP&S 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	The arrangements for receiving feedback from children and families may involve surveys, focus groups and / or other arrangements. They may be part of Trust-Wide arrangements so long as issues relating to children's services can be identified.
PG-201	BI MP&S	**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.	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.
PG-202	BI	**Lead Anaesthetist for Paediatric Critical Care (PCC units only)** A nominated consultant anaesthetist should have lead responsibility for support to paediatric critical care.	This consultant may be the same as the lead anaesthetist (QS PG 201) or the GICU lead consultant (QS PG-203) or may be different.
PG-203	BI MP&S	**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.	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 PM-506). 2 It is desirable in all units that the lead nurse is a senior nurse with specific competences in paediatric critical care.

PG-204	MP&S Doc	**On Site Anaesthetist** An anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management should be immediately available at all times.	1 'Immediately available' means able to attend within five minutes. 2 This QS duplicates QS PC-204. It is included so that a full picture of paediatric anaesthesia responsibilities can be gathered. Notes to PC-204 also apply, in particular, note 5 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.".

PG-205	MP&S 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.	1 This QS duplicates QS PC-205. It is included so that a full picture of paediatric anaesthesia responsibilities can be gathered. 2 As QS PG-204 note 3.
PG-206	MP&S 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.	As QS PG-204 note 3.

PG-207	MP&S	**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.	Relevant CPD may include participation in departmental audit programmes.
PG-208	MP&S 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.	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
PG-209	MP&S 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.	

PG-401	Visit MP&S	**Induction and Recovery Areas** Child-friendly paediatric induction and recovery areas should be available within the theatre environment.	Child-friendly' should include visual and, ideally, sound separation from adult patients.
PG-402	Visit MP&S	**Day Surgery** Children needing elective surgery should be admitted to a day surgery unit or a children's ward area specifically identified for children's day surgery.	
PG-403	Visit MP&S	**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.	A list of drugs and equipment needed for paediatric resuscitation is available on The Paediatric Intensive Care Society website http://picsociety.uk/ .

PG-404	Visit MP&S	**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 PM-506) should be available and checked in accordance with local policy.	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 PM-506).
PG-501	MP&S 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.	
PG-502	MP&S Doc	**GICU Care of Children** If the maintenance guidelines in QS PM-506 include the use of a General Intensive Care Unit, they should specify: a. The circumstances under which a child will be admitted to and stay on the General Intensive Care Unit b. 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	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 PM-506). The criteria for admission should be consistent with the agreed network criteria (QSs PY-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.

PG-503	MP&S 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	
PG-598	Visit MP&S	**Implementation of Trust Guidelines** Staff should be aware of and following Trust guidelines: a. Surgery and anaesthesia for children (QS PC-502) b. Consent c. Organ and tissue donation d. Staff acting outside their area of competence	As QSs PC-502 and PC-598.
PG-601	MP&S	**Liaison with Theatre Manager** There should be close liaison between the lead consultant for paediatric anaesthesia (QS PG-201) and the Theatre Manager with regard to the training and mentoring of support staff.	
PG-602	MP&S	**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.	

PG-701	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.	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 PM-506).
PG-798	MP&S 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'.	1 These arrangements should include feedback to operational staff and should link with Trust-Wide governance arrangements. 2 This QS is additional to Paediatric Critical Care Network review and learning (QS PY-798). 3 This QS is additional to the requirement for reporting and formal review of the death of a child in hospital.
PG-799	Doc	**Document Control** All policies, procedures and guidelines and should comply with Trust document control procedures.	Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of Trust document control policies are not required.

Appendix 3: Clinical and non-clinical equipment / Information Technology

Paediatric Store Cupboard Ward One

- Blood Pressure Monitor: Child Setting
- Blood Pressure Cuffs: Small Child
  Small Adult
- Tempadot or Tympanic Thermometers
- Stethoscope
- Oxygen Saturation Probe- for Dinamap
- Digital Scales (Kept in admissions and in second stage Recovery)
- Medicines for Children formulary (BNF-C)
- Paediatric Group Protocols
- Children's Reward Stickers

Post-Operative Equipment List – Paediatric Oxygen masks

Paediatric Pre-Assessment Area in Assessment Rehabilitation Centre

- Blood Pressure Monitor: Child Setting
- Blood Pressure Cuffs: Small Child
  Small Adult
- Tempadot Thermometers
- Stethoscope
- Oxygen Saturation Probe- for Blood Pressure monitor
- Medicines for Children formulary
- Paediatric Group Protocols
- Children's Reward Stickers
- Oroscope

Identifying and reporting faults

Any equipment in use must function safely. Malfunctioning equipment, or any item believed to possibly be malfunctioning, must be removed from the patient area as soon as it is safe to do so. This applies to both clinical and non-clinical equipment.

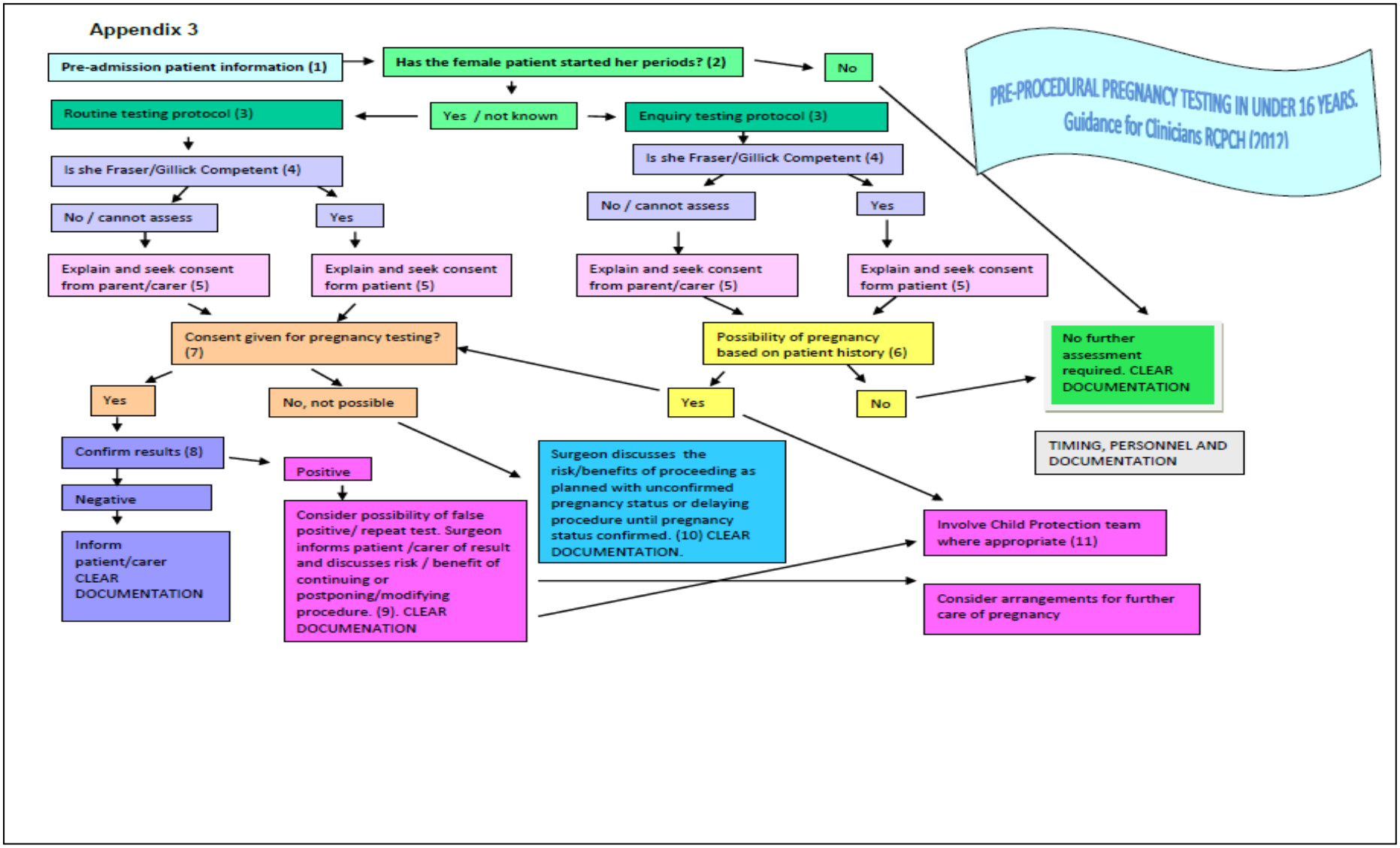
The fault is reported via the telephone help-line, identifying clinical equipment by its code number (present on each piece of equipment). The equipment fault log book will be completed by the staff member reporting the problem, noting the identification number (where relevant), and the date & time of contact with the help desk.

The faulty equipment will be stored separately from other equipment that is fit for use until collected for repair. The item will be clearly labelled as 'faulty' with the date and confirmation of reporting to the help desk.

Where a clinical incident has resulted from equipment failure, or the equipment was in use for a patient, therefore there was the potential for clinical repercussions, the priority is to the patient's clinical need in the first instance. Following and appropriate intervention, as well as process as described, the patient records will be completed to reflect the full details of the incident and any subsequent actions. A clinical incident report will also be completed and forwarded via the management structure to the Clinical Risk Advisor. Any design or functioning fault must also be reported on a national level, to the Medical Devices Agency.

Appendix 4: Notes to the flowchart – Pre-procedural Pregnancy Testing for under 16 year olds (RCPCH Guidance, 2012)

Appendix 3


Pre-admission patient information (1)
Has the female patient started her periods? (2)
No
PRE-PROCEDURAL PREGNANCY TESTING IN UNDER 16 YEARS. Guidance for Clinicians RCPCH (2011)
Routine testing protocol (3)
Yes / not known
Enquiry testing protocol (3)
Is she Fraser/Gillick Competent (4)
Is she Fraser/Gillick Competent (4)
No / cannot assess
Yes
No / cannot assess
Yes
Explain and seek consent from parent/carer (5)
Explain and seek consent form patient (5)
Explain and seek consent from parent/carer (5)
Explain and seek consent form patient (5)
Consent given for pregnancy testing? (7)
Possibility of pregnancy based on patient history (6)
No further assessment required. CLEAR DOCUMENTATION
Yes
No, not possible
Yes
No
TIMING, PERSONNEL AND DOCUMENTATION
Confirm results (8)
Positive
Surgeon discusses the risk/benefits of proceeding as planned with unconfirmed pregnancy status or delaying procedure until pregnancy status confirmed. (10) CLEAR DOCUMENTATION.
Involve Child Protection team where appropriate (11)
Negative
Inform patient/carer CLEAR DOCUMENTATION
Consider possibility of false positive/ repeat test. Surgeon informs patient /carer of result and discusses risk / benefit of continuing or postponing/modifying procedure. (9). CLEAR DOCUMENATION
Consider arrangements for further care of pregnancy

Numbers refer to the boxes in the chart

1 Pre-admission patient information, written appropriately for female patients under 16 and their carers, will aid greatly in reducing elements of embarrassment and sensitivity during subsequent questioning about pregnancy on admission. Examples of information for display or leaflets and key elements to include can be found on:www.rcpch.ac.uk/pregnancychecks

2 A wide variance in the onset of menarche is reported (7-17 years) and pregnancies have been reported in females aged less than 12 years.(vii,viii) Whincup et al. report nearly 1% will have their first menstrual period before their tenth birthday and this increases to over 21% by their twelfth birthday.ix However, prevalence data indicates that the likelihood of pregnancy in those under 13 years presenting for clinical diagnosis or treatment is negligible.

3 There are two possible options for ascertaining pregnancy status in female patients presenting for surgery or investigation – directed enquiry or consented urine testing. In adult practice, directed enquiry is usual, with consented testing as appropriate in circumstances where pregnancy status is uncertain. Directed enquiry in females under 16 years may not however reveal all pregnancies for the reasons detailed in section 3.6.

In general, the likelihood of pregnancy in female patients under 15 years is low and the risks associated with most types of procedure are also low. However there may be certain procedures that would be considered particularly high risk to an undisclosed pregnancy, such as surgery to the lower abdomen, or that involving per-operative x-ray screening to the lower abdomen or pelvis, such as scoliosis or hip surgery. In such cases, consented testing of urine to exclude pregnancy may be considered appropriate by local teams. A suggested (and not-exhaustive) list of some of these potentially high-risk procedures is given on the RCPCH website: www.rcpch.ac.uk/pregnancychecks

4 Decisions to involve parents and carers in discussions on sexual activity and the need for pregnancy testing must be taken using professional judgement and consideration of relevant guidelines such as around Gillick Competence and the Department of Health. Decisions will be based on the patient's age, maturity and ability to appreciate what is involved in terms of the implications and risks to themselves. A judgement may already have been made regarding a young person's competence to give their own consent to the planned procedure, but it is known that competence to make one decision does not necessarily indicate competence to make all decisions. The differing legal elements of determination of competence within the UK also must be taken into account.

5 Female patients under 16 years who may be pregnant have a right to be asked about pregnancy in confidence separately from their parent/carer, and any information disclosed should be used in confidence unless there are overriding safeguarding considerations. It is sometimes difficult to contrive a way to separate patients from their parents to ask sensitive questions, but it may be enough to suggest that as the patient is nearly an adult, there are a couple of questions they may like to answer by themselves in private. The parents may then be asked to leave the room, or the patient given the opportunity to move to a private space with the healthcare professional. Given the responsibility that parents have for the conduct and welfare of their children, professionals should encourage the patient, at all points, to share information with their parents and carers wherever safe to do so.

In the case of a young patient with severe disability (eg severe cerebral palsy), the clinician caring for the patient may consider the possibility of pregnancy to be so remote that neither enquiry nor testing are necessary. This decision should however be documented.

6 Patients should be questioned sensitively about whether they have started their periods, and if so, when was the date of their last period. If this was more than 30 days before the proposed procedure, they should be asked if there is any possibility they could be pregnant, qualifying this by asking if they are sexually active in a way which could result in pregnancy. They might also be asked at this stage whether they are taking oral contraceptive medication. If the patient reveals a possibility of pregnancy, as yet undetected or undisclosed, she should be asked if she will provide a urine sample and her consent gained for a pregnancy test. If questioning reveals pregnancy is unlikely, no further intervention is necessary and this should be documented appropriately.

7 Consent must be overtly obtained for pregnancy testing following specific questioning and provision of any explanation necessary. Sensitive handling of the discussion is required particularly where the age of the patient or indications of cultural sensitivity around premarital or under-age sexual activity are considerations. Surgical consent forms may specifically include mention of the need to ascertain pregnancy status as part of the consent process. A minimum requirement should be that verbal consent to pregnancy testing is recorded in the admission documentation, preferably as part of the patient's integrated care plan.

Whilst generalising or making assumptions about the beliefs of individual patients or their families is wholly inappropriate, development of a protocol locally should involve consideration and involvement of any prevalent groups who may find discussion of pregnancy with females under 16 years and their families a particularly sensitive issue. Furthermore it is essential to have a professional interpreter, or independent advocate if this helps the family or patient to make decisions. The GMC guidance on personal beliefs and medical practice provides further information.

A sample of urine obtained for standard urinalysis should not be used for pregnancy testing without the patient's knowledge and consent.

The legal framework on consent and confidentiality with particular relevance to children and young people is covered by the General Medical Council publication '0-18 years: guidance for all doctors'(xi). This should be referred to for full references which include England, Wales, Scotland and Northern Ireland, and more detailed explanation.

8 Ward-based consented urine tests, which detect presence of urine human chorionic gonadotropic (urine hCG) within a few days of implantation of an embryo, are used routinely in day case units and surgical wards prior to elective procedures. These tests are commercially available to the general public and are extremely easy to use with a swift result (60 seconds). The purchase cost is under £2 each and the test can be conducted as part of pre-operative procedures thus requiring minimal additional staff resource. Laboratory-based urine analysis may be required where the result of a ward-based test is in doubt, or for confirmation of a positive result. Routine use of laboratory-based tests may introduce inconvenient delays in service provision where patients are admitted on the day of surgery, and systems should be in place to conduct these tests as a clinical priority.

9 Where a ward-based urine test proves positive, it may be prudent to repeat the test and/or organise a laboratory-based urine or serum test to confirm the pregnancy. The possibility of a false positive test should also be considered; causes include failed implantation (early miscarriage) and rare conditions causing elevated HCG levels.

The surgeon should be informed immediately of a positive test and should meet with the patient, with the support of her named nurse, to discuss the result and the implications for the proposed procedure. With the permission of the competent patient, and for patients not considered competent, parents/carers may be asked to join in these discussions.

Based on an analysis of the risk to the pregnancy compared with the anticipated benefits of the surgery, a decision must be made on an individual basis whether to proceed or postpone the surgery. If there is a possibility that the planned surgery will proceed, the anaesthetist should be involved in the risk/benefit discussions with the patient.

The clinical team caring for the patient must also make a judgement about the need to involve the local safeguarding team in the patient's ongoing care and make sure that appropriate advice is given regarding pregnancy management. This would usually involve the patient's general practitioner.

10 In cases where consent for pregnancy testing is denied, the surgeon and clinical team must discuss whether they are willing to proceed with the proposed surgery with unconfirmed pregnancy status, or whether the procedure should be postponed. The risks of proceeding should be explained to the patient and her parents/carers, where appropriate, and an effort made to quantify this risk so that the patient/parent can make an informed decision. On an individual basis, the surgeon may offer the option to consent to the surgery, acknowledging and documenting the risks of unconfirmed pregnancy status. It would be very difficult to quantify any anaesthetic risk in these circumstances. In situations where the risk to an undetected fetus would be considered unacceptable, the surgeon is justified in refusing to undertake the procedure.

11 Children under the age of 13 are considered by law in England and Wales(xii) as unable to consent to sexual intercourse, and disclosure of sexual activity would usually require clinicians to take action under child protection criteria or the Gillick ruling(xiii). Advice should be sought from the safeguarding team with local procedures and contacts in place. The situation is more complicated for girls between 13 and 16 years of age, but any disclosure of coercion, sexual activity with a partner aged over 18 or indications of abuse should prompt discussion with the local safeguarding team.

More detailed information around consent, confidentiality and disclosure relating to sexual activity in those under 16 can be found in helpful guidance from a range of organisations including the RCOG Faculty of Sexual and Reproductive Healthcare (xiv,xv), the British Association for Sexual Health and HIV (BASHH)xvi, Department of Health(xvii and RCGPxviii).

Development and implementation of local protocols for pre-procedure pregnancy testing must involve the named safeguarding nurse and/or doctor to ensure that accurate safeguarding advice is available at all times to staff seeking consent and conducting the tests. It needs to be recognised that this advice may not be available from on-site personnel. Staff involved with determining the pregnancy status of females under 16 should feel confident in handling enquiries and responses around sexual activity and be aware of the legal and safeguarding issues. They should have received safeguarding

training in accordance with intercollegiate guidance(xix) and follow local procedures should a referral be indicated.

The ultimate responsibility for these discussions is with the senior surgeon in the team. In the case of contentious situations surrounding consent or when a positive pregnancy test is obtained, a senior member of the surgical team must be involved in leading the discussion and subsequent response.

12 **Timing and personnel**

Pregnancy status should ideally be ascertained within hours of the planned procedure. Information should be provided pre-operatively, at an outpatient visit or pre-assessment clinic, where there is also an opportunity for the need for questions and/or testing to be mentioned by the surgical team as part of the consent process for surgery. The responsibility for ascertaining pregnancy status on the day of procedure will remain with the surgical team. Local protocol may allow the actual questioning and/or testing to be carried out by a registered nurse admitting the patient to the ward providing the lead surgeon has gained and documented consent and should be done early in admission process to avoid delays. The patient's pregnancy status should therefore be known prior to the start of the operating list and form an essential part of the pre-operative documentation. Clear documentation will also avoid the need for further sensitive discussions in the anaesthetic room, where parents may be present.

13 **Documentation**

Having sought consent for pregnancy testing, it is good practice to inform the patient, and her parents/carers where appropriate, of a negative result. There should be clear documentation of the consent, the testing and the result. Where a result has proved positive, there should be extensive documentation in the medical notes of the clinical and safeguarding actions taken in light of the result.

Suggested minimum documentation in the integrated care plan:

For female patients of child-bearing age:	
Any possibility of pregnancy on questioning?	Yes / No / Unknown
Consent given for pregnancy test?	Yes / No / Unknown
Result of urine test?	Negative /

Appendix 5: Self Discharge against medical advice

Usually plans of care for children and young people are made in partnership with parents and families. However on some occasions parents may disagree with medical and nursing recommendations and wish to take their child home against advice. The following flowchart and appendices include guidance on how to manage this situation.

Parents want to discharge child or young person home against medcial / nursing advice

Discuss treatment with family

- Reasons behind wanting to discharge e.g. care of siblings
- Reasons and rationale behind treatment
- Are there other safe treatment options that could be done at home? (home leave, open access, telephone follow up, oral / inhaled treatment)
- Timing of likely discharge or review for discharge
- Clarify who is with the child and parental responsibility
- Document discussions

Parents still refuse to stay

Parents take child off the ward

Is the child safe to go home?

Consider:

- Observations (e.g. oxygen saturations ≥ 92 in air%, PEWS)
- What treatment is necessary (e.g. IV, Nebuliser, Oxygen)
- Risk of deterioration
- Safeguarding / child in need circumstances

No

Inform Consultant on call
Complete check list for unplanned discharge
Open access for 24-48 hours
Check discharge medicines/Inhaler technique
Advice Leaflet – Open access etc
Confirm address and contact details with family
Ensure list of child protection plans / lists of missing persons is checked
Document discussion and ask parents to sign a declaration of discharge against medical advice form
Document all actions, use safeguarding divider in notes

Child has left the ward

Inform Police and ask to bring back to the ward using emergency police powers if necessary or consider Police 'safe and well' check
Inform Childrens Services

Yes

Put in place other treatment options if necessary (home leave, Orchard follow up, telephone follow up, urgent clinic appointment
Complete check list for unplanned discharge
Open Access for 24-48 hours)
Check discharge medicines/Inhaler technique
Advice Leaflet – Open access etc
Confirm address and contact details with family
Ensure list of child protection plans / lists of missing persons is checked
Explore alternative options for care of siblings. In exceptional circumstances siblings can be accommodated

Affix Patient Label

Che rged against medical advice: Date: ___ / ___ / ___ @ ___: ___ hrs

Action Taken	Comment
Confirm Discharge Address and contact details	
Confirm person discharging CYP has parental responsibility. Yes / No	
Open Access explained and leaflet given: Yes / No	
CYP / Parent Information Leaflet given: Yes / No	Name of Leaflet:
Discharge Medication given: Yes / No / NA	
Medication administration explained to parent. Yes / No / NA	Advice given:
Advice given to CYP and parent on when and how to seek help. Yes / No / NA	
Outpatient Appointment arranged if needed: Yes / No / NA	Appointment Details:
Person with parental responsibility has signed Declaration Form	
Discharge letter completed documenting discharge against medical advice Yes / No	
Health Visitor / School Nurse aware: Yes / No / NA	Name of HV / School Nurse:
Inform Children's Services if CYP has a named Social or Family Support Worker: Yes / No / NA	Name and contact details of professional:
Consider referral to Childrens Services re: Safeguarding. Yes / No / NA	
Consider referral to Orchard Services Yes / No / NA	
Telephone follow up to be undertaken by: Nurse Doctor Specialist Nurse Orchard Services	Details of follow up call:

Completed by: _____ (Signature) Print name: _____

Role: _____ Telephone / Bleep: _____

Affix Patient Label

DISCHARGE AGAINST MEDICAL ADIVCE DECLARATION FOR CHILDREN AND YOUNG PEOPLE

STATEMENT OF PARENT

I,..……

……

parent / carer

of……

……

hereby declare that I wish for my child to bed discharged immediately from

……

……hospital, and affirm that I have made the decision to leave the hospital of my own free will, fully realizing that it is contrary to the medical advice which I have received.

Signed……

Date……..

Name

(print)……

……..

Relationship to the

child……..

STATEMENT OF HEALTH PROFESSIONAL

I have explained to the above parent / carer that I advise that

……

……

….is not discharged from……hospital.

I have explained the risks of discharge. In particular I have explained:

……

……

……

……

……

……

……

……

Signed……

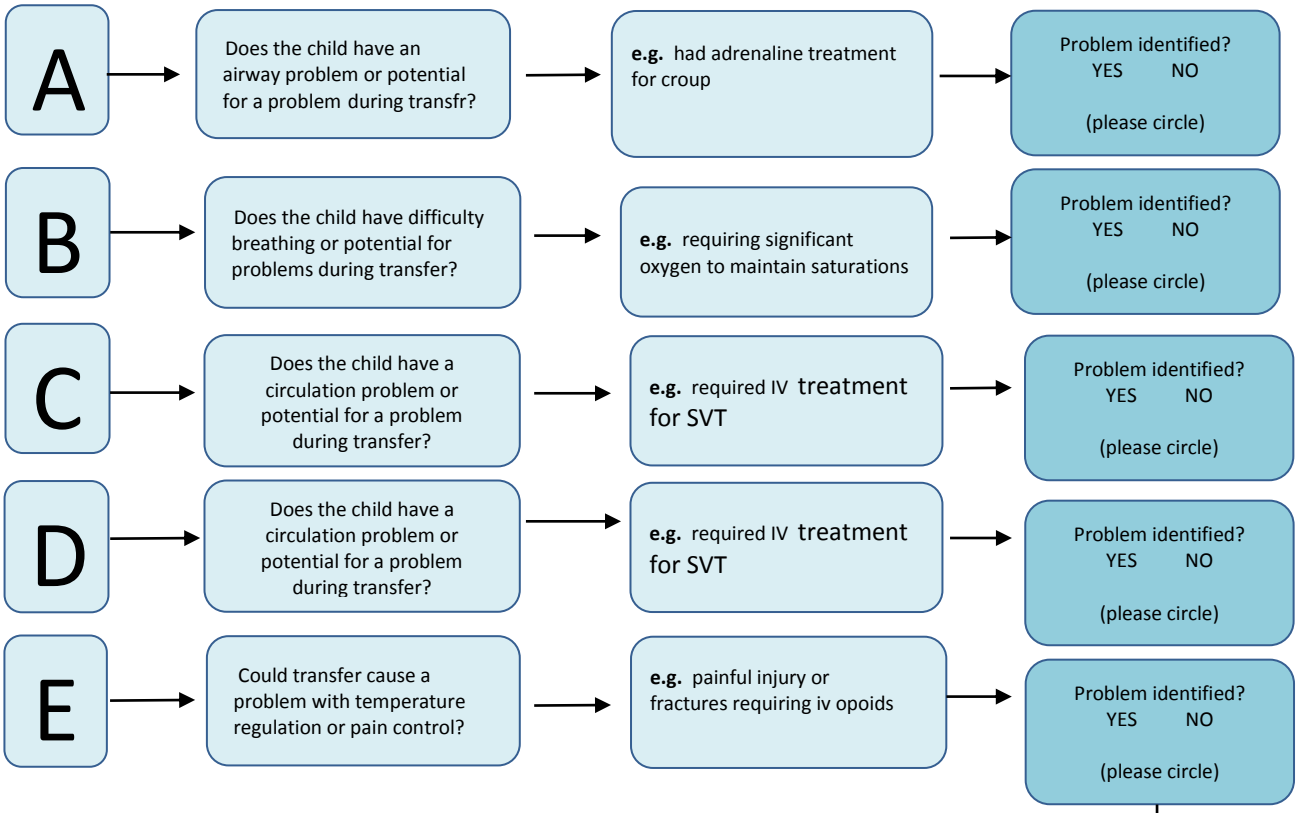
Date……..

Name (print)…… Job title……

Appendix 6: Transfer and Transport Arrangements:
Transfer Patient Stability Assessment Tool

Patient Details
Name

Unit number



ASSIGN Stability (tick)

Stable
= No ABCDE problems

Intermediate stability
= 1 or more ABCDE problems

Unstable
= 2 or more ABCDE problems

Stable

Escort requirements (see also Appendix 5)
No clinician or nurse escort required **unless**
- Parental support for journey needed
- Treatment required en-route not deliverable by ambulance crew e.g. O2 > 30%, continuous drug infusions
- Underlying medical condition liable to unpredictable deterioration
- Requires close nursing care & continuous observation
- PEWS score 4+
- Parental disagreement on lack of escort

Intermediate stability / unstable

Escort requirements (see Appendix 3)
- This will depend upon the clinical problem and may be ambulance crew alone or with nurse or doctor.
- The on-call paediatrician must be informed and a joint decision reached on transport mode, staff escort and equipment requirements

Discussion with KIDS Service
- All unstable and high-risk patients must be discussed with KIDS Team.
- Intermediate stability patients who are at risk of clinical deterioration en route are also best discussed

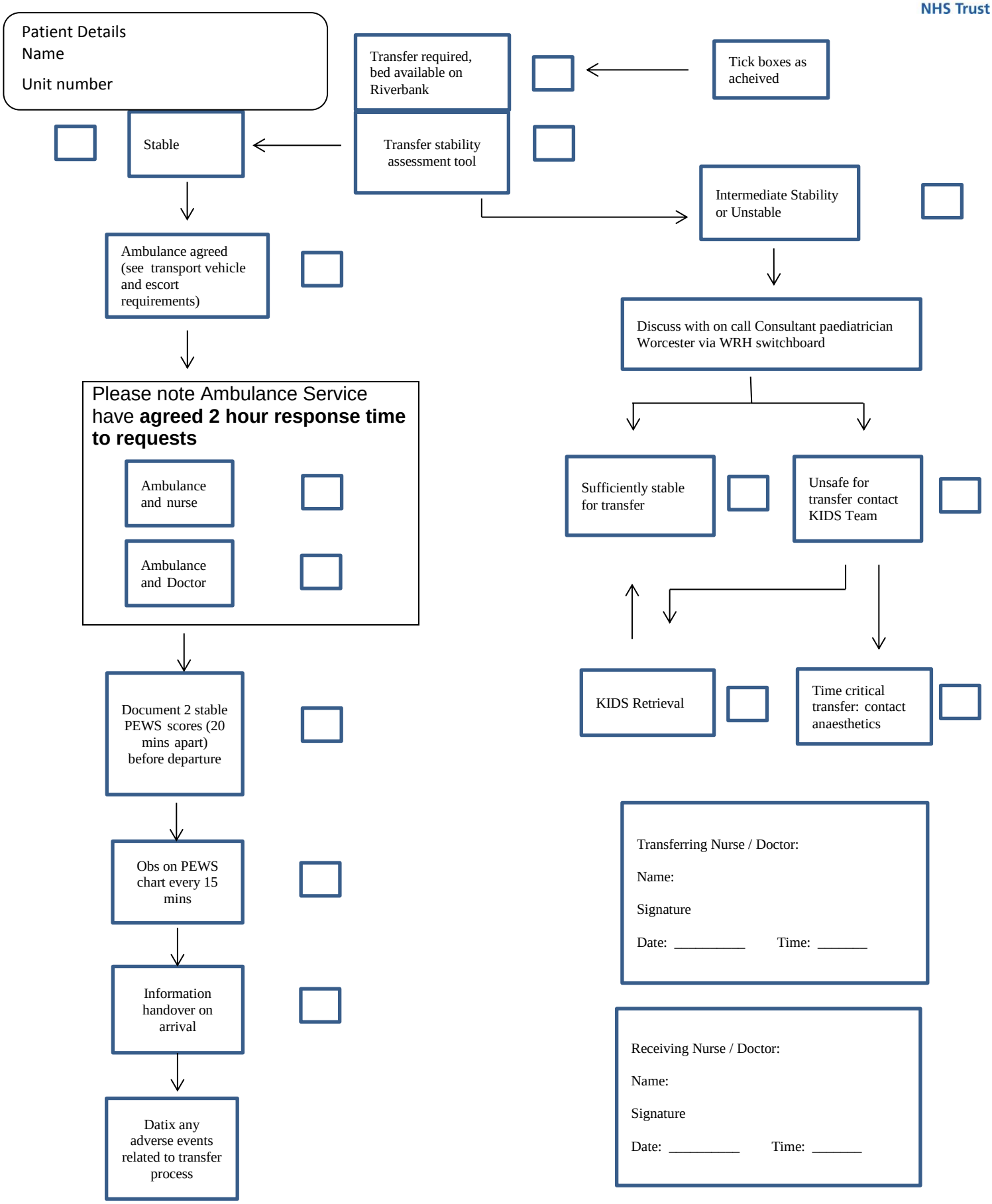
Completed by:

Name: _____

Signature: _____

Role: _____

Date: _____ Time: _____ hrs


Patient Details
Name
Unit number
Transfer required, bed available on Riverbank
Tick boxes as acheived
Stable
Transfer stability assessment tool
Intermediate Stability or Unstable
Ambulance agreed (see transport vehicle and escort requirements)
Discuss with on call Consultant paediatrician Worcester via WRH switchboard
Please note Ambulance Service have **agreed 2 hour response time to requests**
Ambulance and nurse
Ambulance and Doctor
Sufficiently stable for transfer
Unsafe for transfer contact KIDS Team
KIDS Retrieval
Time critical transfer: contact anaesthetics
Document 2 stable PEWS scores (20 mins apart) before departure
Obs on PEWS chart every 15 mins
Information handover on arrival
Datix any adverse events related to transfer process
Transferring Nurse / Doctor:
Name:
Signature
Date: _____ Time: _____
Receiving Nurse / Doctor:
Name:
Signature
Date: _____ Time: _____

Transfer Escort Requirements:

Intervention	Examples	Escort
Nurse intervention possible	IV infusion device care Improving asthma requiring no more than hourly inhalers	Nurse
Medical intervention possible	Asthma requiring intravenous infusion and hourly inhalers Seizure requiring treatment	Paediatrician / Advanced Clinician
May require airway intervention	Intubation possible Clinical instability Time-critical problem	Anaesthetist or KIDS Retrieval Service

Escort Training:

	Minimum	Desirable
Nursing Staff	1. PILS or PLS in past 12 months . Infusion device training	1. APLS or EPLS in past 4 years
Advanced Paediatric Nurse Practitioners	1. APLS or EPLS in past 4 years	1. Transportation scenario in past 12 mths 2. Regional/National Transportation Course
Consultant Paediatricians	1. APLS or EPLS in past 4 years	1. Transportation scenario in past 12 mths 2. Regional/National Transportation Course
Anaesthetists	1. APLS or EPLS/Equivalent experience in past 4 years 2. Transportation training at ST4+ 3. Minimum 6 months paediatric anaesthesia experience or	1. Transportation scenario in past 12 mths

	equivalent	

Implementation
Plan for implementation
Guideline to be disseminated to nursing, medical, paediatric, surgical, anaesthetic and theatre teams
Teams to work in collaboration, highlighting and responding to any issues relating to patient safety in a timely manner.

Dissemination
Inpatient Children and Young Person's Ward
Paediatric Quality Improvement Meeting

Training and awareness
To be included as part of preceptorship and induction/orientation period of new starters in the paediatric nursing team.

Core working group to be assigned to Kidderminster Children's Day Surgery list to ensure continuity and familiarity with the systems and processes supporting Children's Day Surgery.

All staff to have an awareness of how to respond to emergencies and how to summon paediatric support, whilst children's day surgery is in progress.

At minimum one nurse will be an EPLS provider.

Monitoring and compliance
The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

The table below should help to detail the 'Who, What, Where and How' for the monitoring of this policy.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.
	One children's trained nurse to be EPLS provider	Identification of EPLS provider on e-roster	Monthly	E-roster co-ordinator	Ward Manager / Matron to be alerted if unable to provide EPLS provider.	
	Management of pain in children and young people undergoing day surgery	Rolling audit within the anaesthetic department	24 months (?rotate hospital sites for audit)	Anaesthetic/ Childrens Nursing Team	Anaesthetic and Paediatric Countywide meeting	

Policy Review

Policy to be reviewed 2 yearly.

Associated Documents

WAHT-ANA-014: Nil by mouth (NBM) and Peri-operative Medicines Use Guideline.

WAHT- CG-075: Policy for consent to examination or treatment.
Consent Form 2 – Parental consent for a child or young person.
Consent Form 1 – Consent for adults and competent children

WAHT- PAE-075: Paediatric monitoring and observation Guideline. Expires:

WAHT-ANA-009 Paediatric Resuscitation, Stabilisation, retrieval and transfer.

WAHT-CG-025 Resuscitation Policy.

WAHT-CG-567 Incident Reporting Policy.

WAHT-CG-455 Safeguarding Children Policy.

Pre-procedure pregnancy checking above 12 years – RCPCH Guidelines

Standards for Children's Surgery, Children's Surgical Forum (2013)

Background

Consultation

Circulated to the following individuals for comments

Name	Designation
Dr Mike McCabe	Consultant Anaesthetist
Dr Elizabeth Hunt	Consultant Anaesthetist
Dr Emeel Ghobrial	Consultant Anaesthetist
Mat Trotman	Theatre Matron/ manager countywide operating theatres
Ande Joseph	Theatre Lead
Mr Anthony Perry	Consultant General Surgeon
Lara Greenway	Ward Manager
Karen Haley-Hyde	Junior Sister
Melissa Davies	Staff Nurse
Nikki Best	Senior Staff Nurse
Joy Powell	Play Leader
Bev Darbyshire	Staff Nurse Children's Clinic

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Dr Andrew Short	Women & Children's Divisional Medical Director
Dr Graham James	Surgical Divisional Medical Director
Dr Julian Berlet	SCSD Divisional Medical Director

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Dr Tom Dawson	Paediatric Quality Improvement Meeting

18.2 Approval process

Ratified by: Paediatric Quality Improvement Meeting