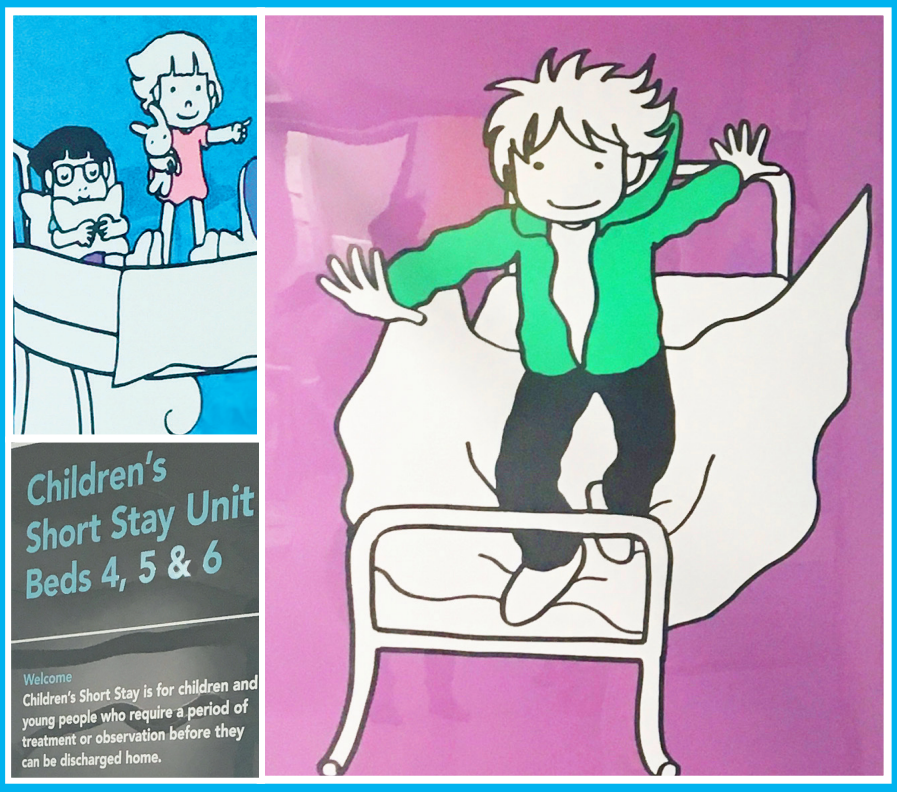
Standards for Short-Stay Paediatric Assessment Units (SSPAU)

March 2017



Front cover illustrations from Evelina London Children's Short Stay Unit by Art in Site

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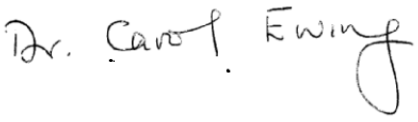
Foreword

With current, well-documented pressures on healthcare services, particularly in urgent and emergency care, there are opportunities to develop creative solutions that deliver a high standard of care to all infants, children and young people.

Short-Stay Paediatric Assessment Units have emerged as an increasingly common component of urgent and emergency care for children and as a hub for the provision and coordination of emergency ambulatory care. Developing standards for all units across the UK, which apply regardless of local arrangements, is vital to guide the development of new units and to provide existing units with measures to audit against. It is envisaged that these standards will be of value to commissioners, service planners, managers and practitioners alike.

The standards have been developed by a multidisciplinary team with extensive experience of working in or with such units. Feedback on the standards has been constructive and positive, recognising that the standards are relevant, necessary and will support the delivery of safe, effective and efficient care to infants, children and young people within this environment. We look forward to working with you to implement them.

Dr John Criddle
Chair of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings



Dr Carol Ewing
Vice President for Health Policy, RCPCH

Background and Case for Change

The pressures on urgent and emergency care services continue to dominate the headlines and are a daily concern for many patients using the services and the healthcare professionals who work there.

When addressing the challenges faced, the unique needs of infants, children and young people must be considered. Over 20% of total emergency department attendances are by infants, children and young people and there are 2.5 times more attendances by children aged fifteen and under than by people aged 80 and over[1]. The number of emergency attendances and admissions annually continues to grow: there were 4.4 million emergency attendances by infants, children and young people (15 years and under) in 2015-16, an increase of 7.6% on 2014-15[1]; and 1.1 million emergency admissions in 2015-16 for children and young people up to the age of 24, an increase of 13% from 2006/07, and for children aged 1-4 an increase of 28%[2]. While GPs remain the most widely used and trusted source of advice for the parents of sick children[3], an increasing proportion of infants, children and young people are admitted to hospital through emergency departments and not through their GP[4]. In 2015/16, 62% of all emergency admissions for infants, children and young people were via emergency departments compared to 60% in 2006/7; and in 2015/16, 22% were referred from a GP compared to 24% in 2006/7[2].

Alongside increasing attendance and admission rates, the duration of admissions is reducing[4]. Approximately 85% of all unplanned admissions are isolated short stays of under two days and 'zero-day' (less than 24 hours) admissions are increasingly common[5]. For the 0-24 age group:

- The mean length of stay following emergency admission has decreased from 2.02 days in 2006/07 to 1.63 days in 2015/16[2]
- Short stays (zero days/admission and discharge on the same day) have increased by 20% between 2006/7 and 2015/16; from 2603 emergency admissions per 100,000 population in 2006/7 to 3117 emergency admissions per 100,000 population in 2015/16[2].

Admissions of shorter duration can be partly explained by the inherent nature of the conditions infants, children and young people present with acutely, mainly low acuity conditions with rapid recovery times. Rapid recovery may be common but so too is rapid deterioration and a period of observation with access to acute care facilities can be useful to more accurately determine a child's clinical trajectory[6].

In general, infants, children and young people should not be admitted to a hospital if it is possibly avoidable and a whole system approach to care redesign in England has been called for in the Five Year Forward View[7].

The joint RCPCH, Royal College of Nursing and Royal College of General Practitioners *Facing the Future: Together for Child Health*[8] standards aim to reduce unnecessary attendances at the emergency department and admissions to hospital. Establishing well-defined, effective links between primary and secondary care is vital. Strategies include direct communication between primary care and paediatricians via a GP 'hotline' and developing 'Hospital at Home' services and connected care with community children's nursing teams[8].

Whilst there are some conditions that can be appropriately managed outside of the hospital, some children will require a period of hospital admission. Admission to an inpatient ward for a child for less than a day can be unsettling for both the child and family and comes with an unnecessary financial cost to the service.

The priority for clinicians working with acutely unwell children is to manage children safely and effectively, in the most appropriate setting. For some, this will require an admission to an inpatient ward, but there are many other children who can be safely managed within a Short-Stay Paediatric Assessment Unit (SSPAU), preventing an inpatient admission.

The SSPAU is well placed to be an integral component of an effective model of care for infants, children and young people. The SSPAU must form part of a whole systems approach for urgent care so that the SSPAU and linked care pathways function safely and effectively within a clinical network for a defined geographical area. The SSPAU must have, for example, robust links to acute services both in primary care and secondary care.

Since the RCPCH produced its SSPAU advisory guidance in 2009[9], there have been many changes to the healthcare system. Over the last eight years the number of SSPAUs has increased from 144 to 178 and commissioners and service planners are increasingly looking to the provision of acute children's services in this environment[10,11]. It is paramount that the care provided within these units meets the same high standard of care afforded to children admitted to inpatient wards and the standards in this document have been developed with this in mind.

Role and Function of Short-Stay Paediatric Assessment Units

For the acutely presenting infant, child or young person, a dedicated facility providing assessment, observation and treatment of an illness, without the need for inpatient admission can be a safe and efficient way of managing their care[12]. These facilities can be organised in a variety of ways and children can be admitted via different routes depending on local arrangements.

Definition and Function

The naming of units shows wide variation across the UK. Some of the terms currently used for this type of facility are given below:

- Ambulatory care unit
- Ambulatory unit
- Acute paediatric assessment unit
- (Children's) clinical decision unit
- Child assessment unit
- Day assessment unit
- Emergency assessment unit
- Holding room
- Observation, assessment and admission ward
- Observation unit
- Paediatric assessment unit
- Paediatric observation area
- Rapid treatment and assessment unit
- Short-stay unit
- Short-stay paediatric assessment unit
- Short-stay paediatric observation unit

The RCPCH Workforce Census 2015[11] found that, within the UK, the majority of units of this type are termed either short-stay paediatric assessment units or paediatric assessment units. For the purpose of this document, the term 'Short-Stay Paediatric Assessment Unit (SSPAU)' will be used, defined as:

A hospital-based facility in which infants, children and young people with acute illness, injury or other urgent referrals from clinicians can be assessed, investigated, observed and treated with an expectation of discharge in less than 24 hours.

The core function of units, regardless of how they are termed, should conform to the definition above, operating within the wider urgent and emergency care system and delivering safe and high quality care.

Benefits of an SSPAU

An SSPAU can provide safe and efficient patient care across the range of children's age groups and for a variety of different conditions[13-15]. The presence of an SSPAU can result in an overall reduction in the number of inpatient admissions, a higher turnover of patients and reduced length of stay due to earlier discharge when compared with other inpatient environments[6,12,15,16]. Patients may also be referred to community services earlier with well-integrated services.

The benefits of the service should extend to improved patient and family experience. This can be measured by providing a platform for children and young people and their families to provide feedback on the service. SSPAUs have been shown to be effective in delivering care which has been rated favourably by parents of patients using these services, including a greater level of satisfaction and reports of reduced anxiety[17].

Location of the SSPAU

In addition to the variation in terminology used for SSPAUs, the location of SSPAUs in relation to the provision of other emergency and paediatric services varies considerably across the UK depending on local circumstances.

Co-location of units with either children's inpatient wards or emergency departments allows for efficiencies and flexibility in staffing which, as a result, is usually more robust. Units which are geographically adjacent to other children's areas including in the emergency department can allow flexibility in managing peaks in attendance rates. When this occurs it is essential that equipment and staffing is appropriate for the clinical care being provided in each area. Attendance and admission documentation processes can often be streamlined when SSPAUs are co-located with other children's services.

SSPAUs co-located with the inpatient ward are most common in the UK (68.8% of units[11]) but, as the prevalence of SSPAUs has increased, co-location with the emergency department is also emerging. Co-locating units with the emergency department may result in a higher turnover of patients and the same may be achieved with units co-located with the inpatient ward[6].

SSPAUs co-located with emergency departments are more common in London when compared with the rest of the UK; 35% of SSPAUs in London, compared to approximately 21.3% across the UK[11,18]. Across the UK, where the SSPAU is co-located with an emergency department, 90.6% are dedicated children's emergency departments[11].

A small number of units (10/141) co-located with the emergency department are on sites without 24-hour inpatient care and inpatient provision is provided elsewhere, at a different site to the SSPAU[11]. Very few units (6/141) are on sites with neither paediatric inpatient facilities nor an emergency department, and stand in isolation[11]. Stand-alone units and units on sites with no inpatient provision may generate increased transfer risks with incumbent clinical risk. Commissioners/service planners should apply stringent risk assessments so that care pathways for the provision of emergency assessment and care in such units are safe, effective and regularly evaluated. The staffing of such units will present a specific challenge, particularly if the paediatric staff are also covering standalone maternity services which offer neonatal inpatient care. It is especially important that SSPAUs which are stand-alone, on sites without paediatric inpatient provision, or which operate less than 24/7, operate as part of a managed clinical network.

Staffing and Workforce

The RCPCH Workforce Census 2015[11] indicates wide variation in the type of staff working in SSPAUs and in the rostering arrangements. Co-location with the inpatient ward is indicative of an SSPAU staffed by paediatricians and children's nurses. In units co-located with the emergency department, children are often seen by emergency department staff with paediatric expertise, either before and/or after admission to the SSPAU.

Specific staffing arrangements will depend on local arrangements and the rota of staff at different levels. Regardless of local arrangements, there are standards regarding senior level medical care that should be adhered to. Staffing must promote senior assessment, review and decision making around infants, children and young people at the earliest opportunity in the acute pathway.

It is important that senior clinical staff are involved in decisions around admission and discharge to and from SSPAUs; as per the previous guidance on SSPAUs published in 2009, 'senior clinical staff should be involved in gate-keeping'[9]. The revised RCPCH *Facing the Future: Standards for Acute General Paediatric Services* published in 2015 also state that 'every child who is admitted to a paediatric department with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier two (middle grade) paediatric rota within four hours of admission'[19]. SSPAUs are unique in that an admission and discharge could take place in under four hours. However, regardless of length of stay, it is still very important that the admission and discharge of a patient occurs with the input of senior clinical staff.

Opening Hours

Infants, children and young people present at hospitals at all times of the day and night. Half of SSPAUs (50.7%) across the UK are open 24 hours a day, seven days a week and the majority (73.2%) are open seven days a week[11]. Units not open 24/7 will have a part-time opening arrangement whereby the unit will close for a period of time overnight and/or at weekends; specific arrangements will vary locally. Of importance are the arrangements in place for when a unit closes, either not admitting a patient to the unit if their length of stay is predicted to extend into hours when the unit will not be open or ensuring patients have a safe handover of care when the unit closes.

Referral to the SSPAU

The most common route for admission to an SSPAU is via the emergency department. Referrals may also be received from primary care and other healthcare professionals, either directly to the unit or through the emergency department for initial triage and diagnosis before confirming the child's care as most suitably managed within the SSPAU. Routes and rates of referral will vary depending on the unit.

Management of Conditions in the SSPAU

There is evidence from SSPAUs in the UK and their equivalents overseas that they can provide effective care for infants, children and young people for a range of conditions[15,16,20-25]. Triage and diagnostic tools have been developed and refined to facilitate categorisation of a child's illness both in nature and severity. Inclusion and exclusion criteria can be applied to ensure that only patients with illnesses that can be suitably managed by the resources available (including staff and equipment) are admitted.

The range of conditions typically treated within an SSPAU are: asthma, respiratory tract infections, gastroenteritis, poor fluid intake, fever, rash, minor head injuries or trauma, abdominal pain, seizures, accidental poisoning, intoxication, self-harm and injury, and post procedure sedation[6].

Provided that patients presenting with these conditions are selected correctly, with an anticipated short stay and a clear idea of time for discharge, there is a wide scope for the range of patients whose care can be safely and efficiently managed within SSPAUs without a need for inpatient admission. Additionally, there is evidence that for certain conditions the introduction of an SSPAU has led to improved outcomes, both in reduced inpatient admissions and length of stay[12,13,16].

Tariffs for SSPAUs

There is no nationally agreed tariff in England for SSPAUs and current tariff arrangements and coding systems make evaluation of this model of care difficult. There is potential for a reduction of cost due to the reduced number of admissions and reduced length of stay compared to an inpatient facility.

Paediatricians and managers should work with commissioners locally to agree a tariff appropriate to their unit (locally negotiated tariff). This will need to be tailored to the specific function of the unit as set out in the service specification and the average length of stay; for example, a short *attendance* for an assessment and immediate discharge may be categorised differently from an *admission* with a longer stay of up to 24 hours focussed on assessment and subsequent treatments. The tariff should reflect the cost of running the service including staffing and any additional services provided by the unit such as GP hotlines, rapid access clinics or community children's nursing teams.

Standards for Short-Stay Paediatric Assessment Units

Governance

Clear governance structures must be in place locally for the SSPAU, accountable to the Trust/Health Board.

SSPAUs operate within a healthcare environment which is both dynamic and evolving, and strong relationships between an SSPAU and community services, primary care, urgent and emergency care, secondary and specialist paediatric services are essential. Clinical networks strategically bring together clinical services in order to provide high quality, coordinated care for a local population and all SSPAUs should operate as part a clinical network. SSPAUs should have a clear governance model with a robust operational policy describing the service provision for the unit, including clear lines of responsibility to senior clinical staff.

Clinical care on an SSPAU will be derived from an increasing number of national guidelines (for example, sepsis, asthma etc.) and should contribute to a range of clinical care and performance indicators. These should be agreed with commissioners/service planners and local management so that they can be audited against and improvements made. Performance indicators should include children and young people and parent/carer satisfaction surveys. Alongside processes for implementing learning, this will drive quality improvement.

	Standard	Audit measure	Reference
1.	The SSPAU operates as part of a regional paediatric network of local and specialised children's services.	- Network level agreement	*26,27*
2.	A Standard Operating Policy (SOP) must be in place with a named senior paediatrician and named senior children's nurse responsible for the management and coordination of the service.	- Copy of SOP - Named senior paediatrician - Named senior nurse	28
3.	Clear pathways for access, referral and admission to the SSPAU (including defined inclusion and exclusion criteria) and for escalation of care and discharge must be in place and audited against.	- Network level agreement - Copies of pathways - Evidence of audits	13,15,27
4.	Trust/Health Board safeguarding polices and processes are in place and followed.	- Policy within unit - Evidence of named safeguarding nurse and doctor	*27,29,30*
5.	Evidence-based guidelines are used for the management of conditions with which infants, children and young people may be admitted to the SSPAU.	- Network level agreement - Use of protocols, guidance and appropriate toolkits	*13,31*
6.	Agreed pathways for shared care with speciality teams such as Child and Adolescent Mental Health Services (CAMHS), general paediatric surgery, orthopaedic surgery, Ear Nose and Throat (ENT), plastic surgery, ophthalmology, oral surgery and dentistry, maxillofacial, gynaecology and neurosurgery must be in place.	- Network level agreement - Copies of pathways - List of main leads with contact details available within service	*28,32*
7.	Each SSPAU audits their performance against locally agreed care quality indicators.	- Evidence of audit and performance against the agreed indicators	*13,28*

8.	Processes must be in place for implementing learning from complaints, compliments, transfers and adverse events.	- Minutes of meetings and case reviews - Evidence of change implemented where appropriate	*28*

Environment and Hours of Operation

Maintaining an environment which is safe and suitable for infants, children and young people up to the agreed age of admission to the unit is essential at all times. This includes the physical environment, the staff who work within it and safe systems and processes that support staff and protect patients and the public.

The benefits of providing a single clinical pathway for an SSPAU, regardless of the time of day, are clear. However, smaller units may not be viable when attendances are reduced. Where units are not open 24/7, they should be open during hours of peak demand, which usually includes the afternoon and evening including Saturdays and Sundays. Demand profiles should be kept under regular review.

The physical environment of the unit should be designed based on the needs of all infants, children and young people, including teenagers, from the start, with provision of suitable areas with toys and equipment appropriate for the wide range of developmental ages involved. Medical equipment for children of all ages must be provided.

	Standard	Audit measure	Reference
9.	The unit must have its own dedicated footprint with secure, restricted access to ensure the safety and security of infants, children and young people.	- Functioning security systems visible - Visual evidence - Audit of area against criteria	*28,32-34*
10.	A child and young person friendly and developmentally appropriate play area must be available for all infants, children and young people.	- Site visit including involvement of children and young people	*32,33,35*
11.	Hours of operation should match times of population demand of the SSPAU.	- Copy of SOP	*19*
12.	Equipment must be available to support the day-to-day activity on the unit as well as resuscitation, stabilisation and transfer of infants, children and young people who become critically unwell.	- Documented list of equipment, presence of equipment and evidence of checks - Presence of transfer equipment and copies of protocols - Compliance with Resuscitation Council (UK) guidelines	*28*
13.	SSPAUs which provide care for infants, children and young people beyond four hours must include provision for meals, bathroom and parent facilities.	- Visual evidence - Audit of area against criteria	*19,34,35*

Recognition and Management of the Deteriorating Child

Systems must be in place to ensure the SSPAU provides high quality, safe care for all infants, children and young people at all times.

Initial assessment requirements for infants, children and young people admitted to an SSPAU should take into account whole patient pathways. Staff should be trained in the use of paediatric early warning score assessments which should be undertaken regularly upon admission to an SSPAU. Assessment should include consideration to identifying infants, children and young people who could be presenting with sepsis.

Infants, children and young people who are extremely unwell may present to SSPAUs or may deteriorate quickly; a paediatric resuscitation team with appropriate skills must therefore be available at all times the unit is in operation. When there is a clinical need for transfers of infants, children and young people, they should be anticipated and form part of the planned network agreements.

	Standard	Audit measure	Reference
14.	All infants, children and young people accessing the SSPAU must have a standardised initial assessment including pain score within 15 minutes of arrival, if this has not taken place in the emergency department. Regular paediatric early warning score assessments should subsequently be undertaken with appropriate escalation of care.	- Copy of SOP - Evidence of triage system and supporting training programme - Written protocol - Evidence of audit in PEWS - Evidence of training in PEWS	*28,32,36,37*
15.	There is urgent access to a paediatric resuscitation team including personnel with advanced airway, intubation and ventilation skills during all hours of operation.	- On call rota	*28*
16.	Guidelines for the stabilisation and transfer of infants, children and young people must be in place for all of the following situations: - Accessing advice from and transfer to the Paediatric Intensive Care Unit - Inter-hospital transfer - Transfer within the hospital	- Network level agreement - Agreed stabilisation and transfer guidelines	*28*

Promotion of Ambulatory and Community Based Care

The SSPAU should work within a connected system of health, community and social care services, promoting ambulatory and community-based care of infants, children and young people to support admission prevention, care at home and reduced length of stay.

The provision and coordination of emergency ambulatory care should be a core SSPAU function. Wherever possible, infants, children and young people should be actively managed at home, with the necessary support from community child health services. In order to support this, the SSPAU staffing model should support senior-level assessment and decision-making at the earliest possible point in the acute pathway.

The SSPAU should work closely with a community children's nursing team which is able to receive referrals 24 hours a day and available to offer support, advice, home visits and treatments, including IV antibiotics when required. Close liaison with primary care, health visitors, school nursing services and community child health services is key. A regular 'virtual' ward round of patients being looked after in the community, together with easily accessible digital medical records can be important mechanisms to maintain patient safety while caring for children at home.

Communication with the wider health team is an important part of care, which includes sharing written discharge summaries appropriately.

	Standard	Audit measure	Reference
17.	The SSPAU can access support from community children's nursing teams 24 hours a day, seven days a week, with visits as required depending on the needs of the children using the service.	- On call access arrangements - Evidence of acute visits	*8,32,38*
18.	A written discharge summary is sent electronically to the infant, children or young person's GP and other relevant healthcare professionals (including health visitors and school nurses as appropriate) within 24 hours of discharge. A copy of the information is given to the child or young person and their parents and carers.	- Percentage of discharge summaries received by GPs within 24 hours - Percentage of discharge summaries received electronically by GPs - Evidence of copy given to child and parents and carers	*8,32*

Supporting Services

To provide effective and efficient care, relevant support services need to be accessible to the SSPAU during their hours of operation.

In order to provide appropriate care on an SSPAU it is vital to have timely access to the appropriate support services, and that these are accessible during all hours of operation. Pathology laboratories need to provide test results within the short timeframes needed for decision-making on an SSPAU.

Access to a shared child health record is important to support coordinated care and information sharing with healthcare professionals. In England, managers should work to support access to the national Child Protection Information Service (CPIS) so that up-to-date information is available to support safeguarding processes, and telephone access to social services including out-of-hours allows information sharing for the purposes of safeguarding.

	Standard	Audit measure	Reference
19.	The SSPAU has timely access to pathology, radiology and pharmacy services with paediatric-appropriate advice from these services during all hours of operation of the SSPAU.	- Evidenced of hours of opening and policies	*28*
20.	Healthcare professionals assessing or treating infants, children and young people in the SSPAU have access to the child's shared electronic healthcare record.	- Evidence of access to electronic healthcare records	*8*

Communication with Children, Young People and Families

Children, young people and families are asked for feedback on their experience and are involved in the assessment, running and development of the SSPAU.

In line with Article 12 of the United Nations Convention on the Rights of the Child, children and young people should be facilitated to participate in all issues affecting them. Children and young people and their parents/carers should be fully involved in all service development and redesign, which includes SSPAUs.

Children and young people have reported feeling that conversations are focused on the adult accompanying them, that language is inaccessible, and that positive, empowering behaviour is not consistent across all healthcare professionals. Children and young people should be involved in the discussions and decisions that affect their health.

	Standard	Audit measure	Reference
21.	Children and young people and their parents and carers receive regular updates on their condition and management plan, and are fully involved in the decision making process.	- Feedback from children, young people and parents/carers	*28,39*
22.	Children and young people and their parents and carers are provided, at the time of their discharge, with both verbal and written discharge and safety netting information, in a form that is accessible and that they understand.	- Evidence that information is provided - Evidence that child and parent/carer understanding of the information is checked	*8,28,32*
23.	The SSPAU actively engages with children, young people and parents and carers and uses their feedback to inform service delivery and development.	- Evidence of engagement of service users - Evidence of patient involvement in decisions about service development in minutes - Patient experience measures are in place / feedback regularly audited and fed back - Evidence that complaints are used to improve services	*5,28,35*

Staffing

The staffing of the SSPAU supports senior paediatric assessment of the infant, child or young person at the earliest opportunity.

Specific staffing arrangements will depend on local arrangements but should promote senior assessment and decision making at the earliest opportunity in the pathway. Senior review at the time of admission to the SSPAU, either in the emergency department or on the SSPAU is key to ensuring appropriate decision-making.

Emergency medicine clinicians are also skilled in caring for young people on clinical decision units and other short stay wards. Some consultants in emergency medicine have trained to develop and expand their competencies in caring for infants, children and young people, usually through additional subspecialty training in paediatric emergency medicine. Increasingly these consultants will wish to partake in the care of infants, children and young people beyond the four-hour parameter of the emergency department and may wish to partake in rotas providing care for infants, children and young people on the SSPAU. This should be by local agreement.

	Standard	Audit measure	Reference
24.	Every infant, child or young person on the SSPAU with an acute medical problem is seen by a healthcare professional with the appropriate competencies to work on the tier-two (middle grade) paediatric rota within four hours of admission to the unit.	- Network level agreement - Case note audit - Copies of rotas	*19*
25.	Every infant, child or young person on the SSPAU with an acute medical problem is seen by a consultant paediatrician* within 14 hours of admission to the unit, with more immediate review as required according to illness severity or if a member of staff is concerned. *or equivalent staff, associate specialist or specialty doctor who is trained and assessed as competent to work on the paediatric consultant rota. This may include designated consultants, such as paediatric emergency medicine consultants.	- Network level agreement - Case note audit - Copies of rotas	*8*
26.	A consultant paediatrician* is readily available on the hospital site at times of peak activity of the SSPAU and is able to attend the SSPAU at all times within 30 minutes. Throughout all the hours they are open, SSPAUs have access to the opinion of a consultant paediatrician* via telephone.	- Network level agreement - Copies of rotas and job plans	*8,28*
27.	The SSPAU has access to a paediatrician with child protection experience and skills (of at least level three safeguarding competencies) who is available to provide immediate advice and subsequent assessment, if necessary, for all infants, children and young people where there are safeguarding concerns.	- Network level agreement - Copies of rotas.	*8,29*
28.	SSPAU children's nurse staffing comply with Royal College of Nursing guidelines (a minimum of two children's nurses for every six to eight beds) with regular audit of patient acuity using	- Operational policy - Evidence of tool available and staff	*40,41*

	appropriate tools to ensure that levels are appropriate for the number, dependency and case mix of infants, children and young people normally cared for by the service.	trained to use it	
29.	Every infant, child or young person on the SSPAU with an acute medical problem is seen by, or has their case discussed with, a clinician with the necessary skills and competencies before they are discharged. This could be: a paediatrician on the consultant rota*, a paediatrician or clinician who is trained and assessed as competent to work on the tier-two (middle grade) rota, or a registered children's nurse who has completed a recognised advanced children's nurse practitioner programme. Nurse-led discharge, when appropriate should be supported by policy, education & training.	- Copies of rotas - Case note audit	*19*
30.	The SSPAU has access to appropriately qualified play specialists and allied health professionals.	- Copies of rota	*27,32*

Training and Continuing Professional Development (CPD)

Staff have access to the relevant training and CPD through their organisation and feel confident to care for the infants, children and young people within the unit.

The SSPAU provides an ideal training environment for a range of healthcare professionals, from doctors training in both emergency and paediatric medicine, to specialist emergency and children's nurses. The environment is also especially appropriate for general practitioners in training and community and advanced nurses who wish to develop their competencies in assessment and management of acutely unwell infants, children and young people.

	Standard	Audit measure	Reference
31.	Nursing staff should possess competencies in triage (where patients have direct access to SSPAU), recognition and management of the deteriorating child, including resuscitation and pain management.	- Copies of training records, and evidence of completing competencies	*34*
32.	All clinical staff have appropriate, up-to-date paediatric resuscitation training. At least one member of staff with advanced paediatric resuscitation provider certification must be available at all times.	- Copies of training records	*28*

Practice Examples

Unit	Paediatric Observation Unit (POU) Royal Derby Hospital	Children's Assessment Unit (CAU) West Suffolk Hospital
Location	Co-located with the Children's Emergency Department.	Co-located with the Paediatric Inpatient Ward.
Opening hours	Open 9am-2am, seven days a week.	Open 24 hours, seven days a week.
Role and function	The purpose of the POU is to provide better quality of care for children and families by ensuring continuity of care from the same doctor and shorter overall length of stay as the doctor can review investigations and discharge the child.	The CAU was developed to improve the quality and efficiency of the service provided for children presenting as an emergency. It provides urgent assessment, observation, diagnostics and treatment for children who do not need an inpatient admission. Some planned episodes of care are also seen.
Population	Children under 17 years of age. Children should have an anticipated discharge within eight hours of admission to the POU.	Children under 16 years of age (with exceptions for some vulnerable older children). Children are only admitted to the CAU if their expected length of stay is less than 24 hours.
Number of beds	Four beds in bays and one cubicle.	Five beds in a bay and three side rooms.
Wider hospital	POU open since 2014. The POU (and Children's Emergency Department) is part of Derbyshire Children's Hospital which has three paediatric inpatient wards (medical, surgical and high dependency).	CAU open since 2010. The CAU is co-located with the inpatient ward (Rainbow Ward) on the first floor of the hospital. The Emergency Department is located on the ground floor of the hospital.
Referral and access	The single front door policy means that all children come to Children's Emergency Department to be triaged, treated	May be referred by the emergency department, GP/out-of-hours service or clinicians in the community. There are also a limited number of children who

	and prepared either for inpatient admission, observation (in the POU) or discharge home.	have open access to CAU and the unit may also be used for paediatric follow ups.
Patient journey	Patients are admitted to the POU under the duty Children's Emergency Department Consultant. Once a bed has been booked, the transfer to it should occur within 20 minutes. Children should have a clear admission plan and discharge criteria. Any investigations should be done prior to admission to the POU. Nurse-led discharge can occur according to certain pathways. Children and their families are given an idea of the time and circumstances around their discharge at the time of admission, with regular updates as necessary. If the patient is identified at any time to need onward inpatient admission the reason for this must be clearly stated in the notes and discussed with the parents. The POU closes at 2am each night. A consultant is resident until 11pm, at which time they carry out a ward round to decide plans for remaining patients. A spike in onward admission occurs around closing but rates remain low (21 admissions out of 204 POU attendances in October 2016).	There is a dedicated entrance to the CAU. All children are greeted on arrival by the ward clerk/reception staff and triaged within 15 minutes by an experienced children's nurse. The nurse assessment includes a focused history with an initial examination of the child (including a PEWS score). Care pathways are used to assist in the assessment and to make a judgement about appropriate placement. All children are reviewed by a paediatric doctor/advanced nurse practitioner within one hour of arrival. A decision regarding admission or discharge should be completed within four hours of the child's arrival and in all cases within eight hours. If a child's condition changes and their length of stay exceeds the agreed maximum 24 hours for the CAU then they will be transferred internally to the inpatient unit. Nursing staff with appropriate skills and competencies are able to review children and facilitate discharge.

Staffing	The POU has at least one nurse in charge at all times (supported by nurses in the Children's Emergency Department), with additional help from an allocated healthcare assistant. A consultant is resident from 9am to 11pm with access to a consultant available during all opening hours (from 11pm to 2am this is via the general paediatric consultant on-call).	Overall responsibility lies with the Paediatrician of the Week and Sister in Charge of the shift. The CAU is staffed from a dedicated pool of children's nursing staff, including one advanced nurse practitioner. Where doctors are rostered to CAU it is expected that they will be present in this area with an experienced senior paediatrician available 24-hours a day.
Outcomes	Reports are generated each month and discussed at departmental meetings. Measures include number of attendances, onward admission rates and length of stay. The average length of stay is 150 minutes (range: 23 minutes to 11 hours). Since the opening of the POU, admissions to the inpatient ward have fallen from 16% to 12% and with the recent extension of the POU opening hours to 2am this has fallen further to 8.9%.	The CAU audits its performance against the East of England standards and patient feedback is gathered through milk bottle lids to provide a rating of the service. Patient satisfaction surveys have also been collected and a high rate of satisfaction has been recorded in a number of areas. 85% of children on the CAU have a length of stay of less than 24 hours.
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Appendix A - Project Board Membership

Dr John Criddle (Chair)	Chair, Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings
Dr Jason Barling	RCPCH representative on the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings
Dr Melanie Clements	Medical Director, Hinchingbrooke Health Care NHS Trust and Consultant Paediatrician West Suffolk NHS Foundation Trust
Sue Eardley	Head of Invited Reviews, RCPCH
Dr Carol Ewing	Vice President for Health Policy, RCPCH
Mrs Julie Flaherty	Royal College of Nursing representative on the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings
Dr Steve Foster	Paediatrician, Queen Elizabeth University Hospital Glasgow
Dr Dani Hall	Association of Paediatric Emergency Medicine representative on Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings
Isobel Howe	Policy Lead, RCPCH
Matthew Jordan	Research Administrator, RCPCH
Dr Gulamabbas Khakoo	Paediatricians in Medical Management Committee
Dr Rachael Mitchell	Paediatrician, Lewisham and Greenwich NHS Trust
Dr David Shortland	Paediatricians in Medical Management Committee
Dr Stephanie Smith	Emergency Paediatric Consultant, Nottingham Children's Hospital
Dr Felicity Taylor	RCPCH Trainee representative on the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings and Paediatricians in Medical Management Committee
Rachel Winch	Workforce Projects Lead, RCPCH

Appendix B - Development of the Standards

The development of the standards has been overseen by a Project Board in conjunction with the RCPCH Paediatricians in Medical Management Committee and the Intercollegiate Committee on Standards for Children and Young People in Emergency Care Settings.

Stage One: Analysis

Systematic literature review

As part of the evidence base for the standards a systematic literature review was carried out. The review looked at how SSPAUs and their equivalents could improve outcomes for infants, children and young people (including reducing length of stay, reducing emergency re-attendances and readmissions and improving patient experience).

Key databases including Medline, Embase and the Cochrane Database of Systematic Reviews were searched in April 2016, returning 12,910 papers. Following a title screen this was reduced to 79 papers and following an abstract screen this was reduced further to 44 papers. The full texts were acquired and the reference lists from these papers screened, identifying an additional three papers for inclusion, taking the total to 47 papers.

Papers were appraised and key data were extracted and collated into evidence tables.

Views of children and young people and their families

The RCPCH recognises that children and their families are not only beneficiaries of healthcare but also key stakeholders with invaluable insights and experiences. The RCPCH works strategically through its &Us network to ensure the voices of children and young people meaningfully informed and influenced the development of the standards.

Call for evidence

A call for evidence was issued although this did not add to the existing list of papers.

Workforce Census

Within the 2015 RCPCH Workforce Census a set of questions about SSPAUs and equivalent units was included in order to inform the development of the standards.

The census included the following questions relating to SSPAUs:

- How many SSPAU or equivalent units does this hospital have?
- What type of SSPAU or equivalent is this unit?
- Where is the SSPAU or equivalent located?
- Total hours SSPAU open per week
- For each of the staff groups, indicate how they work in the SSPAU.

Responses were received from 142 units. Additional sources were used to verify the existence of additional SSPAUs, which total 178 across the UK.

Stage Two: Formulation of the Standards

The evidence from the literature review, call for evidence and workforce survey was evaluated by the Project Board. Drawing on the best evidence available, draft standards were developed. Where there was insufficient evidence, standards were agreed by consensus.

Although SSPAUs are now widespread and in existence in a number of hospitals, there is little published evidence on SSPAUs. There is a need for high quality research to enable informed service change.

Stage Three: Consultation

The draft standards were circulated to key RCPCH committees and to external stakeholders to ensure they were: relevant and achievable; specific and measureable; clear and consistent; to identify any gaps and suggestions for additional standards; and to engage users and key stakeholders.

An open consultation was published on the RCPCH website to seek feedback on the draft standards. Thirty-three responses were received through the online form on the RCPCH website. Additional responses were provided via email.

Site visits

In order to further explore the efficacy of the standards, site visits were organised between May and December 2016 to the following sites:

- Royal Hospital for Children (as part of Queen Elizabeth University Hospital), Glasgow
- University Hospital Lewisham
- King's College Hospital
- Royal Derby Hospital
- West Suffolk Hospital

The purpose of the visits was to 'road test' the standards on the ground to ensure their viability whilst providing an opportunity to highlight examples of good practice or to identify potential challenges around their implementation.

Feedback from consultation and the site visits was considered by the Project Board and the standards were refined prior to endorsement by the RCPCH.

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