



Standards for Children and Young People in Emergency Care Settings

Developed by the Intercollegiate Committee for Standards for
Children and Young People in Emergency Care Settings

British Association of Paediatric Surgeons
College of Emergency Medicine
Joint Royal Colleges Ambulance Liaison Committee
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health

RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health

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Foreword

Children and young people deserve the highest standards of care¹. Since the original *Accident and Emergency Services for Children* was published in 1999 and updated in 2007 there have been significant changes to urgent care health provision in the UK. Care is now provided in minor injury units, walk in centres and pharmacies as well as emergency departments.

Paediatric emergency medicine has continued to evolve and is now a recognised subspecialty for training from both emergency medicine and paediatrics.

The Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings has remained active since its inception in 1999. It sits within the committee structure of the Royal College of Paediatrics and Child Health (RCPCH). It has been responsible for developing a number of guidance and standards documents²³⁴⁵ relating to all aspects of emergency and urgent care for children and young people.

Challenges still exist; ever increasing attendances at emergency and urgent care settings, the impact of the European Working Time Directive (EWTD) on availability of staff and increased public expectation of immediate access to care all require service planners to take a renewed approach to emergency healthcare.

The original publication was widely used in the UK to improve the care of children in emergency settings. This third edition of the 1999 guidance has been renamed *Standards for Children and Young People in Emergency Care Settings* and has incorporated chapters specifically related to young people and mental health, together with consolidating others towards a more 'pathway' approach. The committee members commend this publication to you and hope you find the standards practical, useful and achievable.



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Chair, Intercollegiate Committee for Standards for Children and Young People in
Emergency Care Settings
2012

Executive Summary

Complete list of standards for children and young people in emergency care settings

Standard	Page
Service design: an integrated urgent care system	
<ol style="list-style-type: none"> 1. All staff delivering urgent care to children are competent in the basic skills required for safe practice, in whichever setting they work 2. Service planners, commissioners and providers work together to provide safe urgent care for children in a geographical network, taking local needs into account 3. Healthcare organisations encourage shared or rotational posts, or regular secondments to the acute unit 4. Emergency departments work with local community providers to develop care pathways for common conditions to facilitate care closer to home 5. The <i>Urgent and Emergency Care Clinical Audit Toolkit</i> is used to review individual clinician consultations systematically wherever children with urgent care needs are assessed, including on the telephone, face to face, in hospital or in the community 6. Regional critical care networks are in place to develop protocols to stabilise and transfer children to specialist centres 	10-13
Environment in emergency care settings	
<ol style="list-style-type: none"> 1. Emergency care settings accommodate the needs of children, young people and accompanying families and comply with DH <i>You're Welcome</i> and HBN 22 standards 2. As well as audio-visual separation from adults, consideration is given to security issues, availability of food and drink, breast-feeding areas, and hygienic, safe play facilities 3. At least one clinical cubicle or trolley space for every 5,000 annual child attendances is dedicated to children 4. Young people have access to quieter waiting and treatment areas, and age-appropriate games, music or films 5. Emergency departments seeing more than 16,000 children per year employ play specialists at peak times or have access to a play specialist service 6. Participation is encouraged by children, young people, siblings, parents and carers regarding on going quality and improvement of services or facilities 	14-16

Management of the sick or injured child	
<ol style="list-style-type: none">1. All facilities receiving sick or injured children are equipped with an appropriate range of drugs and equipment (appendix 2)2. All children attending emergency care settings are visually assessed by a registered practitioner immediately upon arrival, to identify an unresponsive or critically ill/injured child3. An initial clinical assessment occurs within 15 minutes of arrival4. A system of prioritisation for full assessment is in place if the waiting time exceeds 15 minutes5. Initial assessment includes a pain score6. Analgesia is dispensed for moderate and severe pain within 20 minutes of arrival7. Individualised management plans are accessible for children who attend the emergency care setting with priority access e.g. 'emergency passport/card holder'8. Systems are in place to ensure safe discharge of children or young people, including advice to families on when and where to access further care if necessary9. All urgent care attendances in children and young people are notified to the primary care team: ideally both the GP and the health visitor/school nurse	17-19

Staffing and training	
<ol style="list-style-type: none"> 1. Nurses working in emergency care settings in which children are seen require a minimum level of knowledge, skills and competence in both emergency nursing skills and in the care of children and young people 2. Acute healthcare providers facilitate additional training in paediatric skills for the nursing staff in the emergency department, and have a long-term strategy for recruitment and retention of registered children’s nurses 3. All clinical staff working in emergency settings have a minimum level of knowledge, skills and competence in caring for children and young people, e.g. recognition of serious illness, basic life support, pain assessment, and identification of vulnerable patients 4. All emergency departments receiving children have a lead RN[Children] nurse and a lead nurse responsible for safeguarding children 5. Sufficient RN[Children] nurses are employed to provide one per shift in emergency departments receiving children 6. In emergency care settings where nurses work autonomously to see and treat patients (usually called ENPs) these nurses undergo an assessment of competencies in the anatomical, physiological and psychological differences of children 7. Emergency doctors and nurses are familiar with local guidelines and know when and how to access more senior or specialist advice promptly for children 8. Level one ultrasound competency is recommended for medical staff training in emergency medicine 9. Emergency care settings seeing more than 16,000 children per annum employ a consultant with sub-specialty training in paediatric emergency medicine 10. All staff working in facilities where children present are trained in paediatric basic life support. Emergency department nursing staff should be PILS/PLS or equivalent trained. Senior trainees and consultants in emergency medicine, paediatrics and anaesthetics dealing with acutely unwell children should be trained to an appropriate level dependent on role (appendix 3) 11. Urgent help is available for advanced airway management and intubation and ventilation is only carried out by competent staff 12. If paediatric on-site support is unavailable, the paediatric skills of the emergency department staff are enhanced, or additional paediatrically-trained staff employed 	20-26

Safeguarding in emergency care settings	
<ol style="list-style-type: none"> 1. All staff are aware of and follow the recommendations outlined in statutory, royal college and other key guidance 2. All staff receive appropriate safeguarding training in line with the guidance document <i>Safeguarding Children and Young People: roles and competences for health care staff</i> 3. All emergency departments nominate a lead consultant and a lead nurse responsible for safeguarding 4. All emergency care settings have guidelines for safeguarding children and young people and include the 'safety net' arrangements 5. All staff in emergency care settings are able to access child protection advice 24 hours a day from a paediatrician with child protection expertise 6. Direct or indirect access to the Child Protection Plan is available 7. Systems are in place to identify children and young people who attend frequently 8. The primary care team, including GP and health visitor/school nurse, are informed, within an agreed timescale, of each attendance 9. A review of the notes is undertaken by a senior doctor or nurse when a child or young person is not brought for a follow-up appointment, or if they leave the department without being seen 10. When treating adults, staff must recognise the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents, and take appropriate action 	27-29
Mental health, substance and alcohol misuse	
<ol style="list-style-type: none"> 1. Emergency clinicians with responsibility for the care of children and young people receive training in how to assess and manage their mental health needs and support their family/carers 2. Emergency clinicians are familiar with current legislation surrounding consent, confidentiality, mental capacity and safeguarding 3. Local policies are in place for the involvement of a mental health practitioner for those children and young people at immediate risk 4. Policies are in place for the management of an acutely distressed child or young person incorporating the use of restraint for those acutely disturbed or at risk of harm to themselves or others 5. Policies are in place detailing the action required when adults with carer responsibilities present with acute mental illness or are identified as having alcohol or substance misuse problems 6. Adequate space is available for children/families in crisis and should include a private room with suitable supervision by emergency staff 7. There is improved access to mental health records and development of individual crisis plans 8. A liaison health worker is appointed to improve access to information, education and clinical expertise 	30-32
Major incidents involving children or young people	
<ol style="list-style-type: none"> 1. All healthcare organisations ensure children are included in major incident plans and are involved routinely in appropriate major incident exercises 2. In establishing a local network of hospitals, statutory agencies and other services, children are specifically considered 	33-34

Death of a child	
<ol style="list-style-type: none"> 1. Local checklists based on national recommendations are used in all emergency care settings 2. All children dying unexpectedly are taken to the emergency department unless there is a need to preserve a crime scene 3. The consultant paediatrician on call is advised as soon as possible about an unexpected child death 4. A consultant in paediatrics or emergency medicine receives early information about the death of a child 5. Parents are offered an appointment to see the bereavement counsellor swiftly and a relevant consultant at a suitable time interval 6. There is co-operation with the Rapid Response Team as well as Child Death Overview panels 	35-37
Information system and data analysis	
<ol style="list-style-type: none"> 1. The needs of patients, clinicians, managers, service planners/commissioners and regulators are defined, and used to inform the development of emergency care setting information systems 2. Emergency care setting staff participate in the national information technology agenda and engage proactively to design local systems 3. There is a minimum dataset which incorporates the specific needs of children 4. Emergency care setting information systems link up with other health information systems, so that data on all local health service contacts are available with the emergency care setting 5. Injury surveillance data is collected and accessible as appropriate 6. Hospitals subscribe to the Trauma Audit and Research Network (TARN), to assess their own outcomes for patients with major trauma and national audits such as CEM analgesia in children with injuries 7. All providers of urgent and emergency care monitor the care provided for children using nationally defined indicator sets and use this, and additional data, when planning service improvement and proposing further quality indicators 8. Emergency care settings utilise the resources of research networks to participate in and plan research projects 	38-40

1. Purpose and scope of this document

The 2012 *Standards for children and young people in emergency care settings* provides healthcare professionals, providers, service planners and commissioners with clear standards of care applicable to all urgent and emergency care settings across the UK. Measurable and auditable, these standards are designed to improve the experience and outcomes of children and young people in their journey through the urgent and emergency care system.

This version replaces the 2007 edition and reflects changes in the way care is delivered. It shifts from making 'recommendations' to setting 'standards' in order to set out accountabilities and support service planning and commissioning.

All the principles of this document apply to NHS in Scotland, Wales and Northern Ireland but for ease we have used terminology for England except where specified and nomenclature is therefore interchangeable. A glossary provides detail in appendix 1.

Definitions

Throughout this edition we refer to both emergency and urgent care settings, the definitions of which have been periodically reviewed and amended by various professional bodies. In this edition we have adopted the term defined by the Department of Health (DH) and noted in the RCGP Centre for Commissioning *Guidance for Commissioning Integrated Urgent and Emergency Care - A 'Whole System' approach*.

'Urgent and emergency care is the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly.' (DH, 2011)

In this document the term 'children' should be taken as meaning 'children and young people'. The term 'child' refers to people under the age of eighteen years unless separately specified.

2. Current challenges facing paediatric emergency care

In the last twenty years we have seen dramatic changes to the way that urgent and emergency care for children and young people is provided. In the 1990s it was likely that a family would contact their own general practitioner (GP) practice when they had urgent concerns about one of their children. Changes to GP working practices since the new GMS contract in 2004 have resulted in a multiplicity of emergency care settings and providers, but still demand grows. In 2006/7 there were over three million attendances by children (0-16) in UK emergency departments. In 2010/11 this figure was 4,511,713.⁶

Pathways for urgent and unscheduled care are complex. Families can obtain advice from NHS Direct, NHS24 (Scotland) or through NHS111 (England). Children may be seen in a range of settings such as a pharmacy, GP practice, walk-in centre, emergency department or children's assessment unit. Numerous professionals can be involved in this pathway: GPs, practice nurses, children's nurses, emergency department staff, paediatricians, emergency nurse practitioners and emergency care practitioners and the objective is that wherever families or children access the system, there are suitably trained and knowledgeable staff to direct, diagnose or treat them.

There are many challenges in delivering and developing urgent care pathways. The health changes in England are stimulating new approaches to commissioning urgent and emergency care through pathways and networks within a climate of competition and multiple providers. The RCPCH publication *Facing the Future* has predicted that there would need to be a reduction of approx. 50 paediatric inpatient units in order for the defined acute service standards to be achieved with the current and proposed consultant workforce in the UK. The NHS Outcomes Framework (England) recognises that patient experience is an important aspect of the quality of care provided and a focus on outcome measures can stimulate integrated working, if appropriately designed to measure outcomes across whole pathways. Development of Health and Wellbeing Boards, clinical senates and Clinical Commissioning Groups (CCGs) (in England) will have an important role in ensuring that providers work in a coordinated way to deliver care.

With regard to emergency care settings it is important that there is further progress in key quality and safety areas, including facilities to allow audio-visual separation of children from adults, the use of paediatric pain scores at triage, the provision of a resuscitation area specific for children, the employment of a senior nurse to lead on paediatric issues and the employment of an appropriate liaison paediatrician. For the future, it is extremely important that there is integrated workforce planning which recognises the multi-professional nature of pathways and networks for urgent and unscheduled care and that new working practices (for example the role of community children's nurses in supporting these pathways for children) are recognised and developed.

3. Service design: an integrated urgent care system

The vast majority of consultations with children with undifferentiated urgent care needs occur outside emergency care settings, and this chapter outlines the wider integrated pathway and the role of emergency care setting within them.

Workforce

A number of different health professionals have contact with children and families needing urgent or emergency care, including GPs, nurse practitioners, radiologists, physician assistants, emergency care practitioners and pharmacists. Given the skill mix of professionals involved in the care of children with urgent care needs in different settings, whether face to face on the telephone or through formal telephone triage and advice systems, multidisciplinary training and attainment of specified competencies should be envisaged in the future right across the care pathway (see chapter 6 staffing and training issues).

Increasingly telephone consultation and triage is being conducted by GPs or nurses. Telephone assessments will be conducted by non-clinicians who receive specific competency-based training and ongoing review. Such activity should use proven clinical decision support software (CDSS). This may be NHS Pathways in England which is linked to the NHS111 and NHS Direct services and in Scotland the NHS24 website and telephone number provide non-emergency health advice. In Wales, NHS Direct Wales applies.

Once specified competencies have been attained through core training, the various health professions so far have had different approaches to review using systematic routine clinical audit of consultations. The medical royal colleges and other stakeholders have supported development of an *Urgent and emergency care clinical audit toolkit* designed for professional use anywhere along the care pathway for children with urgent care needs.⁷ Use of this toolkit in every clinical setting involving patients with urgent care needs should reduce the variability of the quality of the clinical consultation and promote a consistent approach.

Reconfiguration of local services

The aim of providing expert help as early as possible in a child's illness, in order to improve clinical outcomes, has to be balanced by the importance of accessible services as close as possible to home.^{8,9} This requires service planners, commissioners and providers to work together to assess need, clarify the roles of different access points, define patients who should be referred to larger, more specialist centres, and identify staff able to take these decisions.

The Scottish Government has described a tiered model of emergency care for children and young people.¹⁰ The DH (England) is proposing that very sick or seriously injured patients are taken directly to larger centres.¹¹

Whenever services are provided at facilities on a part-time basis, the public must be fully informed of the opening hours and know how to access alternative care in a safe and timely way. Where on-site 24-hour paediatric services are not available, emergency services will continue to receive very sick children even where 'bypass' arrangements have been made with the ambulance service, because parents with very sick children (particularly babies and infants) will go directly to the nearest facility. In these situations the paediatric skills of the emergency department staff must be enhanced. This applies particularly to distinguishing minor from more serious illness, life support skills, stabilisation and transfer skills, and child protection awareness. These skills are covered in more detail in chapter 6.

Service planning for acute units in this situation should consider appointing senior paediatric-trained doctors and nurses, for example specialty trainees in emergency medicine (ST4, or equivalent experience in a non-training grade), consultants with sub-specialty training in paediatric emergency medicine, sessions from an appropriately trained consultant paediatrician, and/or a children's nurse practitioner. Radiological support services should be designed and developed in line with national standards.¹² This would normally require Level II support for emergency departments. Anaesthetic and surgical competencies and needs must also be identified (see chapter 6).

Where paediatric advice is not available on site, criteria should be in place detailing when referral to a paediatric centre for assessment and/or admission, or later out-patient management is appropriate. The development of an observation area or short-stay paediatric assessment units (SSPAUs)¹³ can assist in this decision and avoid unnecessary transfers. SSPAU opening hours should reflect attendance patterns and those of surrounding units, and collaboration between senior doctors and nurses in the emergency department and in-patient children's services is essential to enable optimum functioning of such units.

The development of managed clinical networks and community children's nursing teams¹⁴, a flexible approach to traditional professional, organisational and managerial boundaries^{15 16} and an emphasis on the competencies of the emergency department team are key elements in designing a safe service. Cross-site or hospital/community arrangements should be regularly reviewed, to ensure that the service is safe, and to identify issues for further improvement, with seamless integration between hospital and community services.

Emergency care settings without paediatric support should liaise with their local children's unit for expert advice regarding issues of concern including training and development of staff.

When service reconfiguration takes place, service planners, commissioners and providers should ensure that the safety and efficiency of the new arrangements are audited, clinical risks are fully assessed, and the views of patients, carers and staff are taken into account.

A networked approach to urgent care

A whole-systems approach to the provision of urgent care should be taken to ensure a smooth patient journey. Shared protocols, shared training, staff rotations, and quality improvement programmes should operate across the whole geographical area covered by the network. Clinical guidelines and referral pathways should be consistent. Establishment of link posts across the network, for example through staff rotation, will enable the development of consistent skills and appropriate referral patterns. The board level lead for acute children's services should develop ways to make this possible. Where this is not currently possible, regular secondments are an alternative.

Children with illnesses are more likely to be taken to primary care settings (the General Practice in-hours or out-of-hours service or urgent care centre) and those with injuries to emergency departments or minor injury/illness units; however there is much overlap. Staff in all urgent and emergency care settings should be aware that they may not know the full context of the family and consulting with, or referring back to the GP may be appropriate. The GP is in the optimum position to assess the impact of illness on the family, with their background knowledge of the context of the family's health, their social situation and their ability to cope with illness.

Regional critical care networks enable early expert advice to be sought appropriately for acute cases.¹⁷ Each network should audit all critical care management to improve the care of children within the network, and share their experiences with other networks.¹⁸ It is expected that such networks will take on a more 'managed' aspect rather than looser clinical affiliations. Regional critical care networks should include staff from emergency departments, paediatric, anaesthetic and intensive care departments, GPs, GP staff, ambulance organisations, the Paediatric Intensive Care Unit (PICU), the supra-regional retrieval service (if that exists) and all emergency care settings. Co-operation is essential and will allow the formulation of clear primary bypass and secondary transfer protocols when required. Such models of care for trauma have been developed in some regions, with the aid of joint educational meetings and outcome audits.¹⁹ This principle is also endorsed by national standards.²⁰

Liaison with ambulance services

Emergency paediatric care may start with the ambulance service, although less frequently than for adult emergency care, as critically sick children are often brought to the emergency department by car. It is estimated that 5-10% of 999 calls will be to a child, and only a small proportion of these will actually have a condition requiring urgent intervention.²¹ Skill maintenance may therefore be difficult. The emergency department lead consultant for paediatrics should be familiar with the local ambulance training and equipment for paediatrics, and give advice where possible to help ambulance personnel maintain confidence in their skills.

There should be uniformity in the provision of drugs and equipment suitable for children across all ambulance services. All ambulance services should comply with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) clinical practice guidelines.²² All

immediate care practitioners must be competent in caring for sick and injured children, whether they are ambulance technicians, paramedics or emergency care practitioners.

Ambulance teams should be equipped to deliver the initial treatment or advice at home, however it is essential that ambulance staff are competent in the assessment and treatment of children, and, if the decision is made that the child does not require hospital attendance, there should be a system in place to notify the GP and health visitor/school nurse of the consultation.²³

Follow-up in community or ambulatory care settings

The increasing scope of community services to follow up on discharge from emergency department care is welcome. Emergency department staff should be aware of the services available locally for children, to help avoid admissions, enable earlier discharge and make care more family-friendly, including outreach teams, out-patient or day-case care. Children may be discharged from emergency departments to the care of community children's nurses for wound dressings, to check their medical condition is improving (asthma, bronchiolitis, gastroenteritis etc), or for monitoring and managing acute exacerbations of long-term conditions. The DH publication *NHS at Home* covers this in detail.²⁴

Emergency department staff should liaise with paediatric colleagues to construct ambulatory care pathways for suitable conditions. Joint referral protocols should be agreed and their use audited for outcome and safety.

Standards

1. All staff delivering urgent care to children are competent in the key skills required for safe practice, in whichever setting they work
2. Service planners, commissioners and providers work together to provide safe urgent care for children in a geographical network, taking local needs into account
3. Healthcare organisations encourage shared or rotational posts, or regular secondments to the acute unit
4. Emergency departments work with local community providers to develop care pathways for common conditions to facilitate care closer to home
5. The *Urgent and Emergency Care Clinical Audit Toolkit* is used to review individual clinician consultations systematically wherever children with urgent care needs are assessed, including on the telephone, face to face, in hospital or in the community
6. Regional critical care networks are in place to develop protocols to stabilise and transfer children to specialist centres

4. Environment in emergency care settings

All emergency care settings accepting children and young people should be designed to accommodate their needs and those of their accompanying parents, carers and siblings. All grades of staff coming into contact with children and young people should be skilled in communicating with them at an appropriate level; guidance is provided by the General Medical Council (GMC).²⁵ Children should as far as possible be involved in discussions and decisions about their care, which should be tailored to their needs and wishes as far as possible in an atmosphere which promotes dignity, privacy and respect.

Parents will generally be anxious, and must have an opportunity to share their concerns and questions swiftly. Families may be juggling priorities such as the care of other children, and have practical needs such as food and drink for the children, or breastfeeding, nappy-changing, and bottle-warming facilities.

Built environment

Useful recommendations on the built environment in England and Wales can be found in the NHS Estates Health Building Note (HBN) 22: *Accident and Emergency Facilities for Adults and Children*,²⁶ HBN 23: *Hospital Accommodation for Children and Young People*²⁷ and the DH publication *Friendly healthcare environments for children and young people*.²⁸ In general, children's treatment areas require more space per patient than adult areas, for medical equipment, floor space for the child, toys, and space for family members. Children usually prefer being in a larger waiting room with more space, than being in a cubicle. It can be helpful to provide dedicated secure space for parking buggies or pushchairs adjacent to the children's area.

There should be one or more child-friendly clinical cubicles or trolley spaces per 5,000 annual child attendances, and children should be provided with waiting and treatment areas that are audio-visually separated from the potential stress caused by adult patients. Although this may not be possible at all times, every effort must be made to find a reasonable compromise. The needs of bereaved parents/carers should also be accommodated with private areas such as viewing rooms. Children's areas should be monitored securely and zoned off, to protect children from harm. Access should be controlled.

In addition to these basic elements, emergency care settings treating more than 16,000 children per year should have the following:

- facilities for the full resuscitation and also monitoring of high dependency children, as well as those treating more minor illnesses/injuries
- a route to the imaging department which avoids other areas of the emergency care setting if possible
- a cubicle with a door for consultations where privacy and confidentiality is paramount
- appropriate areas suitable for breastfeeding and nappy changing
- a play specialist service to cover peak times, including weekends

Children's wards should be deemed safe places for the initial reception of emergency admissions only if they have an appropriately staffed, equipped and a monitored high dependency area for reception, triage and resuscitation.²⁹

Facilities

A useful checklist of equipment for areas receiving acutely unwell children/young people is provided in appendix 2.

The atmosphere and furniture of the children's area, including reception, waiting and treatment areas should be accessible, welcoming and child-friendly.³⁰ There should be a range of recreational activities appropriate for children of different ages; these should be refreshed regularly. Local charities, donors or media campaigns often assist with this. Murals, mobiles, posters and colourful decoration help allay anxiety and make clinical assessment and treatments much easier for all concerned.

Wherever possible, consideration should be made for older age groups and there should be clear arrangements for accommodation of young people aged 16/17 for whom neither the children nor adult area may be appropriate.³¹ Young people may prefer quieter, more private, surroundings. Provision of appropriate DVDs, CDs or video games for this age group is as important as age-appropriate toys for younger children.

Toys and books must comply with health and safety regulations, and the hospital's play specialists or children's wards can provide appropriate advice e.g. with respect to cleaning toys.

The NSF for Children states that, "*Play is an essential part of the services provided to children in hospital*".³² In smaller departments this service may be shared with in-patient services. Larger emergency care settings should recruit play specialists to cover peak times. Other departments should at least link with the children's department play specialists to gain advice on play and play materials.

The role of a play specialist in emergency care settings includes:³³

- providing distraction therapy for potentially distressing procedures
- enhancing nursing and medical skills to involve play in the management of procedures in children
- maintenance of a child-centred environment, including advising on safe and appropriate toys and facilities
- supervision of play in the department
- advising on the requirements of children with special needs

Information and communication

Advice leaflets about common conditions should be available and specific to children, young people and their parents and guardians. It may be advisable to have different leaflets which are age specific. If the setting discharging the child or young person is not open 24 hours, verbal and written instructions should be given on how the family should access further advice if necessary.

Emergency care settings should use the opportunity to offer wide-ranging advice for young people's wellbeing. Directgov Young People (formally Connexions) is a useful source of advice for drugs, alcohol, family problems and health.³⁴

Where there is a risk that information may be missing or misleading, every effort should be made to obtain a translator, or else consideration given to admitting the child for translation during normal working hours. Phone translation services should always be available but may not be appropriate for safeguarding concerns to be discussed.

Involvement

However emergency care settings are configured, improvements can always be made by listening to the views of the children, young people, siblings, parents and carers. Surveying children at the end of their visit can yield informative feedback, and prompt changes regarding on going quality and improvement, which can often be very simple. Guidance on involving children and young people is available in *Not Just a Phase*.³⁵

Organisations and service planners should utilise the Patient Reported Experience Measure (PREM)³⁶ tool to provide feedback for improvement of services both locally and across a network.

Standards

1. Emergency care settings accommodate the needs of children, young people and accompanying families and comply with DH *You're Welcome* and HBN 22 standards
2. As well as audio-visual separation from adults, consideration is given to security issues, availability of food and drink, breast-feeding areas, and hygienic, safe play facilities
3. At least one clinical cubicle or trolley space for every 5,000 annual child attendances is dedicated to children
4. Young people have access to quieter waiting and treatment areas, and age-appropriate games, music or films
5. Emergency departments seeing more than 16,000 children per year employ play specialists at peak times or have access to a play specialist service
6. Participation is encouraged by children, young people, siblings, parents and carers regarding on going quality and improvement of services or facilities

5. Management of the sick and injured child

Initial assessment

All children or young people attending an emergency care setting must be visually assessed immediately upon arrival and receive an initial triage assessment within 15 minutes of arrival or registration.³⁷ If the waiting time for full clinical assessment exceeds 15 minutes, an interim, brief assessment by a competent and appropriately trained nurse or doctor should take place. This assessment should include recognising the sick child, identifying serious illness or injury (using a standardised system, e.g. The Manchester Triage System)³⁸ completing a pain score and include an assessment of child protection or at-risk status (see chapter 8).

When a child is received, all staff should routinely explain who they are and what service they can or cannot provide for the patient. *You're Welcome* states that: “*Young people [should] not [be] asked any potentially sensitive questions where they may be overheard for example in the reception, waiting areas, ward environment; a child's privacy and dignity must be maintained through their care pathway*”³⁹ See chapter 4 for environment standards.

Relevant treatments/investigations including imaging should be initiated at triage (i.e. within 15 minutes of arrival); careful selection of imaging and its timing should be decided by joint protocols and case-by-case discussion. The receiving area of any emergency care setting should not be left unattended by clinical staff for more than a short period, since critically ill children are often brought unexpectedly by car, rather than by ambulance. All new arrivals must be greeted and kept in view while waiting, so that a deteriorating or critically unwell child can be identified immediately. Emergency care settings should ensure that all children with undifferentiated illness or injury are assessed by staff competent and trained in the assessment of children.⁴⁰ Local policies such as ‘emergency passports’ or ‘fast tracking’ for specific children/young people with long term conditions should be developed separately to the objective allocation of a triage category.

Requirements for analgesia should be assessed at triage, using an appropriate pain score, and treatment of pain delivered within 20 minutes.⁴¹ Particular emphasis should be given to children and young people who cannot express their pain because of age, illness, injury or disability. Where appropriate, children should be provided with the resources to enable them to make informed choices regarding pain relief management; where possible the child's view should be central to the decisions made about their pain relief.⁴² Protocols should be in place for the assessment and management of pain in children and the effectiveness of pain management audited yearly⁴³. The Royal College of Nursing (RCN) pain assessment guidelines recommends reliable and valid tools for measuring pain intensity in children, including those children and young people with cognitive impairment.⁴⁴

Children and young people presenting with mental health or behavioural problems should be triaged according to their clinical as well as their situational urgency. Assessment tools to assist staff in identifying at risk patients should be utilised and should supplement the formal triage assessment (see chapter 9).

Telephone consultation is now common, accompanied by an increase in telephone triage systems in emergency departments, out of hours nurse advisors and health advice lines. Telephone triage is dependent on the quality of the information gathered from the caller. It is recommended that all services using such an approach for the identification of seriously ill children and young people utilise proven clinical decision making software.⁴⁵ This should be supplemented by specific training in the use of these tools and regular audit to determine compliance and reliability. All advice and communication with parents/carers must be clearly documented and recorded for future reference if necessary.

Transfer

In many instances, following initial stabilisation in an acute unit the child will be transferred to a regional centre, where Paediatric Intensive Care (PIC) is usually provided from an organised regional network. Emergency departments should use guidelines (usually already in place within the region), for contacting the regional PIC centre or Retrieval Service. Contact should be made early in these situations, in order to reduce time to transfer and to optimise clinical outcomes. In some circumstances it is necessary for the initial receiving hospital to perform the transfer.^{46 47} It cannot be expected that retrieval teams can provide airway and respiratory support in a timely fashion. Hospitals should ensure that this can be provided safely locally until the transfer has been arranged. Protocols should be agreed within the hospital to ensure rapid availability of skilled personnel. There should be standardised arrangements for transfer within the hospital (e.g. to medical imaging, operating theatres, or other critical care areas) with appropriate equipment.

Safe discharge from emergency care settings

Discharge of children or young people from any setting inevitably carries a risk that some may subsequently deteriorate. Therefore 'safety nets' must be in place, clinical governance systems applied, and monitoring of outcomes performed. The family must always be advised to return if their child's condition deteriorates. For safe discharge, the environment to which a child or young person is being discharged must be taken into account, particularly if there are issues around supervision, safeguarding, or the ability to return to the emergency care setting easily.

Clinical guidelines for any condition must include parameters for safe discharge, for example, ensuring that a child who is tachycardic is not discharged without discussion with a senior doctor. Young people who present following self harm should be managed

according to National Institute for Health and Clinical Excellence (NICE) (England) / Scottish Intercollegiate Guidelines Network SIGN (Scotland) guidelines and admitted to a ward for assessment once medically fit.⁴⁸ Children presenting for a second time with the same illness or injury should not be discharged without review by a consultant or equivalent. In some emergency care settings there is a consistent safety policy of senior medical review of any small infant (e.g. less than three months old) before discharge. Such guidelines should exist, but parameters should be defined locally according to staff skill-mix, specialist availability, and evidence-based practice.

Notification of attendance must be sent to the child's primary care team (GP and health visitor or school nurse),⁴⁹ together with any other professionals involved in the child's care as per local arrangements. The community teams must have systems in place to collate information on attendances from different urgent care providers. A liaison health visitor can be employed to assist with communication to the community and/or screen attendances for child welfare concerns.

Standards

1. All facilities receiving sick or injured children are equipped with an appropriate range of drugs and equipment (appendix 2)
2. All children attending emergency care settings are visually assessed by a registered practitioner immediately upon arrival, to identify an unresponsive or critically ill/injured child
3. An initial clinical assessment occurs within 15 minutes of arrival
4. A system of prioritisation for full assessment is in place if the waiting time exceeds 15 minutes
5. Initial assessment includes a pain score
6. Analgesia is dispensed for moderate and severe pain within 20 minutes of arrival
7. Individualised management plans are accessible for children who attend the emergency care setting with priority access e.g. 'emergency passport/card holder'
8. Systems are in place to ensure safe discharge of children or young people, including advice to families on when and where to access further care if necessary
9. All urgent care attendances in children and young people are notified to the primary care team: ideally both the GP and the health visitor/school nurse

6. Staffing and training issues

Departmental establishment

It is the responsibility of individuals, the emergency care settings team, and the employing organisation to ensure any child or young person is reliably cared for by staff with the necessary competencies, at any time.

A board level lead for acute children's services should ensure that the following leads for the emergency care of children and young people have been identified:

- named consultant paediatrician and lead children's nurse for the emergency setting
- emergency care surgeon leading for children's surgery
- anaesthetist with paediatric training
- consultant and nurse for the Paediatric Intensive Care Retrieval Service
- nurse and doctor for safeguarding
- liaison health visitor
- RN[Children] nurse and doctor responsible for development of policy and practice

These individuals should meet regularly to monitor governance, audit and quality arrangements for children's emergency care and also include the paediatric resuscitation officer and the board level lead for acute children's services and/or clinical governance.

All paediatric departments supporting an on-site emergency care setting seeing more than 16,000 children per year should aim to appoint a consultant with sub-specialty training in paediatric emergency medicine.

The lead nurse/matron with overall responsibility for the emergency department should also have explicit responsibility for developing and maintaining a suitable environment and ensuring the provision of appropriate equipment (see appendix 2).

The Healthcare Commission reported in 2007 that 5% of acute emergency departments in England had insufficient cover for serious paediatric emergencies in the daytime, and 16% out of hours.⁵⁰ The follow-up review in March 2009 reported that the availability of trained staff in management of pain and life-support for children was insufficient in a significant proportion of units.⁵¹

All clinical staff should have minimum competencies including recognition of the sick or injured child, basic life support skills, the ability to initiate appropriate treatment in accordance with locally agreed protocols and effective communication skills, with agreed arrangements in place for transport.

NOTE: The following text summarises the training requirements for staff working in urgent and emergency care settings. This section provides outline guidance only; full details of the knowledge, competences and skills for providers are set out by the medical, nursing and allied health professionals. Professional bodies of the managers and staff must ensure that staffing levels and competences are sufficient for the population of children and young people attending the department; current guidelines and frameworks are referenced in this section.

Life support

Emergency medicine, anaesthetic and paediatric trainees and consultants in these disciplines should be competent (i.e. have been trained and assessed) in advanced life support that is appropriate to their roles. It is recognised that courses such as Advanced Paediatric Life Support (APLS) and European Paediatric Life Support (EPLS) fulfil many of these requirements (see appendix 3 for details). However, it must be recognised that more will be expected from senior practitioners than is currently provided on these courses. Appraisal should identify what training is required and the employing authority must ensure that such training is made available.

Emergency paediatric resuscitation skills should be within the remit of all anaesthetists attending emergency departments. Hospitals with a low throughput of children should ensure that these skills are maintained. This can be achieved by staff secondments or rotations to other centres.^{53 54}

Nursing staff should be trained to at least Paediatric Intermediate Life Support (PILS) or Paediatric Life Support (PLS) level.⁵² Medical and nursing staff should be familiar with the principles of advanced airway support, and induction and maintenance of anaesthesia, and should also be able to assist advanced practitioners competently when required.

Airway skills: basic and advanced

Basic airway skills may be urgently required in any emergency care setting, because parents of extremely sick infants and children often present at the nearest facility without calling an ambulance. Staff must be able to initiate immediate basic airway management.

The lead nurse and consultant should ensure staff are taught, assessed and maintain competence in relevant basic airway skills, which include:

- assessment of airway patency
- use of supplemental oxygen
- choking child manoeuvres
- airway opening manoeuvres
- use of airway adjuncts
- provision of assisted ventilation (bag-valve-mask ventilation)

All receiving units must have a system for summoning urgent help for advanced airway skills, which may include calling 999.

Anaesthetic skills

Induction and maintenance of general anaesthesia in children in emergency departments requires specially trained clinical staff, together with a range of appropriate equipment and drugs. In most places this will only be provided by anaesthetic specialists, although larger departments may have emergency medicine consultants and trainees who are competent and experienced in advanced paediatric airway management.

Staff assisting with paediatric anaesthesia must be adequately trained; these will usually be Operating Department Practitioners (ODPs). Emergency department nurses and doctors should be familiar with the principles of emergency advanced airway management, so that they can work effectively in the team. Competence to provide paediatric anaesthesia will need to be maintained through regular exposure, Continuing Professional Development (CPD) and/or refresher courses and should be checked through audit and review.

Surgical support

The availability of paediatric surgical expertise has decreased in many general hospitals in the last decade. While occasional practice in the continuing care of critically ill children is best avoided by surgeons and anaesthetists who do not usually care for children, immediate stabilisation skills and life-saving surgical skills must be within the competencies of surgeons taking part in an on-call rota covering the emergency department. Steps should be taken by those individuals to avoid deskilling.⁵⁵

The Healthcare Commission found that in 2007 28% of acute trusts in England and Wales reported their availability of trained staff (anaesthetists and surgeons) for emergency paediatric surgery as “poor”.⁵⁶ As expertise in the care of children by anaesthetists and general surgeons in general hospitals has diminished, the importance of effective networking with regional and sub-regional paediatric surgeons increases.

It is the responsibility of commissioners in conjunction with clinicians to identify the surgical expertise available for children and young people within their region. This is vital in order to avoid unnecessary delays in transfer to the appropriate centre should this be required; a survey by the Children’s Surgical Forum (CSF) reported that only 48.5% of District General Hospitals were found able to provide an emergency GPS service in line with recommended standards.⁵⁷

Paediatric support

The consultant's role will involve assisting with training and advising on guidelines and protocols and they should have sufficient protected sessions in their job plan; an absence of on-site children's services must not preclude this arrangement. Emergency care settings should work closely with local children's services to ensure consistency of clinical guidelines and patient pathways, and to share training of staff.

Nursing skills

Nurses caring for sick and injured children in emergency care settings require competences in emergency nursing, including organisational and clinical skills, and in the care of children. A nurse working in any emergency care setting which receives children should be competent in:

- The physiological & psychological developmental of children and young people
- The assessment, measuring and monitoring of vital signs^{58a}
- Pain assessment and management
- Medicines management
- Managing the sick and injured child/young person
- Safeguarding children and young people

The minimum competences in relation to caring for children and young people have been defined by Skills for Health,^{58b} the RCN, the Faculty of Emergency Nursing (FEN), and in the publications *Emergency Care Framework for Children and Young People in Scotland*⁵⁹ and *Maximising Nursing Skills in Caring for Children in Emergency departments*⁶⁰ which defines the competences for nurses with respect to responsibility and seniority when caring for children and young people. Individual departments should consider the level of service they are providing and therefore the levels of nursing competence they require. This approach has been taken by NHS Scotland.

Several universities offer accredited post-registration modules in emergency care of the child and young person for both Registered Nurse (RN) [Adult] and RN[Children] nurses. In addition, competence development should also be supported with the use of rotational opportunities between emergency care settings and children's units. However, healthcare organisations should have in place a long-term strategy for recruitment and retention of RN[Children] nurses, and the secondment of RN[Adult] nurses to undertake training to become registered children's nurses.

There are considerations for nurses who work outside their registration status, i.e. RN[Adult] nurses caring for children, and RN[Children] nurses caring for adults. The Nursing and Midwifery Council (NMC) accepts that registered nurses through the course of their career will have gained knowledge and skills in areas not related to their original registration code and field of practice. However, the care provided by a RN[Adult] nurse should always be conducted under the direct or indirect supervision of a RN[Children] nurse. The supervising registered nurse will remain accountable for the decision to delegate tasks. Therefore RN[Adult] nurses must have supervision until deemed competent to care for children, and RN[Children] nurses must have supervision until deemed competent to

care for adults. As a nurse they are accountable for the actual care they give as well as the decisions they make which is reflected in the NMC code.⁶¹

The RCN recommends a minimum of one RN[Children] nurse to be present at all times.⁶² However, the ability to provide a RN[Children] nurse does not detract from an emergency care setting's responsibility to ensure that all staff have a minimum competence to care for children. Indeed, it is acknowledged that many departments are unable to provide sufficient children's nurses to ensure that one is on duty at all times. In these departments, there should be a plan in place to achieve this, in addition to ensuring that nurses access more detailed education in the care of children and young people, to be able to offer advice and support to other staff.

Autonomous practitioners

In emergency care settings where non-medical practitioners such as emergency nurse practitioners (ENP), emergency care practitioners (ECP) and physician's assistants (PA) work autonomously to see and treat patients, specific education in the anatomical, physiological and psychological differences of children should be attained. They must also have specific training in history taking, examination skills and diagnostic reasoning in children and young people, including interpretation of investigations. Initial face-to-face assessment may also occur in facilities remote from emergency departments with critically unwell children unexpectedly presenting to urgent care centres. Nurse practitioners must have the knowledge and skills to facilitate the stabilisation and transfer of these children.⁶³

For those practitioners with responsibility for the pre-hospital assessment of children with serious illness and injury, up to date training in child protection, pain management and spotting the sick and injured child are essential.

Paramedic practitioners should have opportunities available to access appropriate paediatric life support training courses and participate in joint training with hospital professionals. Consideration should be given to clinical placements in either a children's assessment unit or children's emergency department to maintain skills in caring for acutely unwell/injured children.⁶⁴

Support workers

The delivery of emergency care to children is increasingly supplemented by support roles (e.g. Health Care Assistants (HCA), Physician's Assistants (PAs)) which has proved invaluable in addressing shortages in nursing staff. However these practitioners are often expected to provide care to children without the necessary knowledge, skills or competence. Emergency care settings must therefore ensure that HCAs and support workers are given the opportunity to undertake competency based training with mentorship from registered practitioners competent in caring for children.⁶⁵ Play specialists also have a unique opportunity to complement the care delivered to children and young people within emergency departments and must be respected for their specialist skills in using play for the benefit of children/young people.

Medical skills

All doctors delivering emergency care to acutely ill or injured children or young people should be competent in assessing whether they are reasonably well, potentially seriously unwell, or has a life- or limb-threatening condition. They should institute basic or advanced life support as indicated according to Resuscitation Council (UK) guidelines.⁶⁶ They should have received training in child protection issues⁶⁷ and be able to identify different types of child welfare concern. Chapters 7 and 8 cover these issues in more detail.

All doctors working in emergency care settings should be familiar with local guidelines and have ready access to them. They must know when and how to access more senior or specialist advice promptly.⁶⁸

Foundation doctors and those in basic specialist training will come from different backgrounds, and will usually need to improve their emergency paediatric skills. This can be achieved by attending a one-day PLS or PILS course, or the longer APLS or EPLS courses or equivalent (see appendix 3). The DH (England) interactive website *Spotting the Sick Child* is targeted at doctors at this level of training and can be utilised in conjunction with case reflection.⁶⁹

For doctors in higher specialist training in emergency medicine, paediatric emergency medicine will be taught in year three of core training, and around six months of that year will focus on paediatric emergency medicine competencies. Non-consultant career grade doctors with regular exposure to sick children should attain the same competencies as CT3 trainees.

There is increasing use of ultrasound as a tool in the evaluation of sick or injured patients and level one ultrasound competency is recommended for those training in emergency medicine.

Training of doctors sub-specialising in paediatric emergency medicine

The RCPCH and the College of Emergency Medicine (CEM) have developed a curriculum and assessment system suitable for training both emergency physicians and paediatricians in paediatric emergency medicine (PEM). This joint programme aims to deliver excellence in the reception and care of children in the emergency department setting.⁷⁰ Such examples where these competences would be developed would be trauma management, care of acutely sick children, social paediatrics and child protection, and chronic medical conditions presenting with acute illness.

Information about training and departmental accreditation is available on both the CEM and RCPCH websites. The document *A Framework of Competences for Sub-Specialty Training in Paediatric Emergency Medicine* forms the basis of the training programmes.⁷¹

Standards

1. Nurses working in emergency care settings in which children are seen require a minimum level of knowledge, skill and competence in both emergency nursing skills and in the care of children and young people
2. Acute healthcare providers facilitate additional training in paediatric skills for the nursing staff in the emergency department, and have a long-term strategy for recruitment and retention of registered children's nurses
3. All clinical staff working in emergency settings have a minimum level of knowledge, skills and competencies in caring for children and young people, e.g. recognition of serious illness, basic life support, pain assessment, and identification of vulnerable patients
4. All emergency departments receiving children have a lead RN[Children] nurse and a lead nurse responsible for safeguarding children
5. Sufficient RN[Children] nurses are employed to provide one per shift in emergency departments receiving children
6. In emergency care settings where nurses work autonomously to see and treat patients (usually called ENPs) these nurses undergo an assessment of competencies in the anatomical, physiological and psychological differences of children
7. Emergency doctors and nurses are familiar with local guidelines and know when and how to access more senior or specialist advice promptly for children
8. Level one ultrasound competency is recommended for medical staff training in emergency medicine
9. Emergency care settings seeing more than 16,000 children per annum employ a consultant with sub-specialty training in paediatric emergency medicine
- 10 All staff working in facilities where children present are trained in paediatric basic life support. Emergency department nursing staff should be PILS/PLS or equivalent trained. Senior trainees and consultants in emergency medicine, paediatrics and anaesthetics dealing with acutely unwell children should be trained to an appropriate level dependent on role (appendix 3)
11. Urgent help is available for advanced airway management and intubation and ventilation is only carried out by competent staff
12. If paediatric on-site support is unavailable, the paediatric skills of the emergency department staff are enhanced, or additional paediatrically-trained staff employed

7. Safeguarding in emergency care settings

Safeguarding is a broad term that encompasses protecting children from maltreatment, preventing impairment of health and development and ensuring children have safe and effective care. Safeguarding also includes promoting the welfare of the child and there is an emphasis on detection of vulnerable families, children and young people. Child protection is an element within safeguarding and refers to activity undertaken to protect specific children suffering, or likely to suffer, significant harm.⁷² Regardless of semantics, there remains a clear need for health professionals to both protect those who present with suspected abuse or neglect and retain an active role in seeking to prevent abuse.

Emergency departments may be the first point at which children who have been subject to abuse or neglect come into contact with professionals who are able to act for their protection. All health care organisations have a duty outlined in legislation to make arrangements to safeguard and promote the welfare of children and young people, and to co-operate with other agencies to protect individual children and young people from harm.

The statutory guidance based on the Children Act 2004⁷³ was updated in March 2010. *Working Together to Safeguard Children*⁷⁴ applies to all NHS England and public sector settings and sets out the duties and expectations of staff in urgent and emergency care settings. A revised version is expected to be published in Summer 2012.

It is crucial that all staff in emergency and urgent care settings can identify children and young people who are or may be at risk of abuse or neglect and that there are clear protocols on what to do when abuse or neglect is suspected. Identification includes 'Safety-netting', which is akin to early help; a duty under section 10 Children Act 2004. This means early recognition of vulnerable children and young people and targeting support for the most vulnerable, as well as being clear about how help can be accessed. Staff should also be prepared to reflect on interactions with children and young people and amend practice to ensure a child-focused approach.

Further, all emergency care settings should have agreed protocols, relevant specifically to them, on how to access advice, and actions to take when welfare concerns are raised.

Staff must be able to find out swiftly if a child has recently presented at any other emergency department or been the subject of repeated emergency advice telephone calls and whether the child is the subject of a Child Protection Plan. In some instances this is facilitated through an electronic link to the local social services database, but where this has not been enabled it is essential that all staff know the procedures for determining the child protection status of any child or young person attending the department.

In accordance with *Facing the Future*, 'All children and young people [must] have access to a paediatrician with child protection experience and skills (of at least safeguarding level 3 training) [...] This service must be available to all units on a 24/7 basis.'⁷⁵ There must also be clear guidelines on how these services are accessed out-of-hours.⁷⁶

Aside from the more common forms of abuse and neglect, recent publications are also drawing attention to different forms of abuse which those caring for children should be aware of, such as child sexual exploitation, gang-related and peer violence human trafficking⁷⁷, forced marriages, female genital mutilation⁷⁸ and crimes in the name of honour. This is in addition to groups such as asylum-seeking children, children with disabilities, trafficked children and those who are looked after or in the criminal justice system.

Staff should be particularly aware of families with complex and multiple problems. Parental factors such as substance misuse, domestic violence and mental health problems can indicate that children living under these circumstances are at an increased risk of harm.

Other essential guidance for staff working in emergency settings include the NICE guidance *When to Suspect Child Maltreatment*⁷⁹ and the GMC child protection guidance *Protecting children and young people: the responsibilities of all doctors*.⁸⁰ The CEM has published a set of measurable child protection standards for all departments and a Safeguarding Best Practice Guide and 'safety net' guidance with which emergency departments should comply.⁸¹

All staff working in emergency care settings should have access to training and ongoing supervision in child protection appropriate to their role. Detailed requirements are contained within the intercollegiate safeguarding competences⁸² and summarised in chapter 6.

All emergency care settings should have a clinical lead and senior nurse with responsibility for child protection. There should be a system in place to identify children who present frequently. These cases should be examined at regular intervals and appropriate action taken.

Robust systems are required to inform the primary care team about each child's attendance at an emergency care setting in a timely fashion and ideally both the GP and midwife/health visitor/school nurse. Exceptions can be locally agreed, for example in relation to sexual health issues. Sharing of information can be enhanced by appointing a liaison health visitor. The role and scope of the work of the liaison health visitor varies, but must be matched to the number of children requiring safeguarding, the availability of the settings' named doctor and named nurse for safeguarding, and the availability of information from social services. Systems must be in place in all emergency care settings to identify children and young people who leave before being assessed or who are not brought back for follow-up.

Standards

1. All staff are aware of and follow the recommendations outlined in statutory, royal college and other key guidance
2. All staff receive appropriate safeguarding training in line with the guidance document *Safeguarding Children and Young People: roles and competences for health care staff*
3. All emergency departments nominate a lead consultant and a lead nurse responsible for safeguarding
4. All emergency care settings have guidelines for safeguarding children and young people and include the 'safety net' arrangements
5. All staff in emergency care settings are able to access child protection advice 24 hours a day from a paediatrician with child protection expertise
6. Direct or indirect access to the Child Protection Plan is available
7. Systems are in place to identify children and young people who attend frequently
8. The primary care team, including GP and health visitor/school nurse, are informed, within an agreed timescale, of each attendance
9. A review of the notes is undertaken by a senior doctor or nurse when a child or young person is not brought for a follow-up appointment, or if they leave the department without being seen
10. When treating adults, staff must recognise the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents, and take appropriate action

8. Mental health, substance and alcohol misuse

Mental health and substance misuse present some of the most challenging situations within emergency departments, with an estimated one in ten children aged between 5 and 16 years experiencing a mental health problem, the majority of which will be managed outside specialist mental health units.⁸³ It is imperative therefore that emergency and urgent care staff have the necessary skills to assess and manage a child or young person who presents with an emotional, behavioural or mental health problem.

Emergency care settings are often the first point of contact for vulnerable children and young people with mental health problems, substance misuse, self-harm and other life threatening behaviour, often disadvantaged by family instability, stigma and lack of mental health expertise. Therefore, health professionals are often best placed to instigate the initial treatment which may range from general advice to referral for specialist opinion, while a liaison health worker can support staff with information, training and interagency links. Emergency departments have a responsibility to be able to identify and screen for mental health and associated risks such as substance misuse. The acute encounter with the child or young person should be used as an opportunity to engage them with the relevant Child and Adolescent Mental Health Services (CAMHS) or substance misuse service.

Emergency clinicians recognise the challenges involved in managing this client group, but often feel more skilled in delivering care for acute medical and traumatic presentations. The following information therefore aims to identify areas for consideration by emergency clinicians in an effort to enhance the care of young people presenting with substance/ alcohol misuse or mental health issues.

Challenges for emergency clinicians

The challenges facing emergency clinicians are often multi-factorial and include:

- An environment which is often non-therapeutic for the management of these patients, because of noise, distressing sights, large numbers of people and staff working under immense pressure; in contrast to patients who benefit from time and patience. The environment can result in outbursts of distress or the patient leaving prior to receiving the necessary treatment.
- Access to community mental health is not available for those patients seeking emergency care out of hours. This causes problems for the emergency clinicians who encounter problems with gathering information and organising the necessary follow-up.
- Long waiting times to see a clinician or receive initial assessment.
- Young people may pose particular problems where hospitals separate children's from adult emergency departments, as neither service may take overall responsibility for young people.

Given that presentation in the emergency department is often the first time the patient has required outside help for a problem, referral for a mental health assessment should be requested once a full physical examination and exclusion of organic cause has been

confirmed. In this age group, pharmacological and physical restraint should be regarded as a last resort and clear guidelines must be available. Most situations can be managed by calming manoeuvres or a clear show of force by fully trained staff and the need to instigate restraint should be in the best interest of the child/young person as physical and pharmacological restraints both have the potential for complications. Those who require restraint within the emergency department should be continuously monitored with time limited orders. Documentation must include the indications for such actions, the benefits incurred and that consent could not be obtained because of incapacitation. Only trained personnel should apply restraint and staff must be alert to an unexpected deterioration of the mental or cardiopulmonary status of each patient who requires restraint.

Within the emergency care settings, there must be adequate and appropriate physical space available for those children in crisis, with a private room as the preferred option if available. The ability to observe those patients requiring the administration of psychotropic medication or restraint must be considered prior to instigating such treatment options.

Triggers for identifying children or young people presenting with mental health problems include:

- Bullying: physical or psychological
- Abuse: physical, sexual, emotional and neglect
- Substance misuse and alcohol misuse
- Chronic illness or physical disability
- Learning disability
- Self-harm

Adult patients presenting to emergency care with mental health problems or substance misuse may also have parental responsibilities and therefore concerns for the welfare of a child/young person in their care must be considered and appropriate action taken as indicated. Clinicians must have an understanding of parental responsibility, child protection, right to consent, confidentiality and refusal of treatment. Accompanying adults/carers should be utilised to access further information. See Chapter 7 for more information.

Crisis care plans should be established for frequent presenters to the emergency department, utilising the expertise of the multidisciplinary team (mental health worker, emergency department staff and social services). An electronic alert can be added to the electronic log to inform staff of the patient's attendance and crisis plan.

Specific mental health problems include:

- Anxiety disorder, which may also be associated with illicit drug use
- Depression
- Bi-polar disorder
- Self-harm
- Substance or alcohol misuse
- Conduct disorder
- Eating disorders
- Psychosis, where the cause may be unknown or secondary to illicit drugs, glue or aerosol abuse

In a busy emergency department, it is also easy to dismiss a young person's experience with alcohol as 'normal adolescent behaviour' when a more thorough assessment should include the need to ask why the young person is intoxicated and evaluating for underlying mental health problems such as depression or substance misuse.

Many emergency departments will not have onsite facilities to provide adequate mental health care for children and as a consequence children often require transfer to a more appropriate facility after medical assessment, stabilisation and mental health assessment are completed. Guidelines should therefore be in place for the safe transfer of such patients. For those young people with mental health problems who require medical admission in hospital, guidelines should be in place for managing such patients. The welfare of the child/young person is paramount and there should be robust systems in place to ensure the appropriate follow-up and communication between professionals including local safeguarding teams and social care services.

Prior to discharge, follow-up appointments should be arranged by the emergency clinician and not left as the responsibility of the parent/guardian. It is preferable for appointments to be arranged for within 24-48hrs.

Standards

1. Emergency clinicians with responsibility for the care of children and young people receive training in how to assess and manage their mental health needs and support their family/carers
2. Emergency clinicians are familiar with current legislation surrounding consent, confidentiality, and mental capacity and safeguarding
3. Local policies are in place for the involvement of a mental health practitioner for those children and young people at immediate risk
4. Policies are in place for the management of an acutely distressed child or young person incorporating the use of restraint for those acutely disturbed or at risk of harm to themselves or others
5. Policies are in place detailing the action required when adults with carer responsibilities present with acute mental illness or are identified as having alcohol or substance misuse problems
6. Adequate space is available for children/families in crisis and should include a private room with suitable supervision by emergency staff
7. There is improved access to mental health records and development of individual crisis plans
8. A liaison health worker is appointed to improve access to information, education and clinical expertise

9. Major incidents involving children or young people

All acute healthcare organisations must cater for children and young people in their major incident plan. At a regional level, provision for children is required within a network arrangement, from ambulance arrivals to continuing care.

Planning

The needs of children in a major incident can be considered in terms of the following groups:

- Physical injury - there may be a variety of ages or, in the case of an incident involving a group of children, may include many children of a similar age, which has implications for equipment availability
- Traumatically bereaved - children whose friends or family have been injured, or affected by scenes they have witnessed
- Children who may be brought to the hospital as part of family groups

If a hospital is overwhelmed with attendances, and, in particular, if there is limited access to paediatricians, paediatric intensivists, paediatric anaesthetists or paediatric surgeons, there should be provision in the hospital major incident plan to utilise the services of a local network to support the hospital. This may include special arrangements for transportation of seriously injured children by ambulance to designated centres. Consideration must also be given to ensuring less seriously injured children are taken to the centre where relatives are being treated or will arrive.

Major incidents also include so called 'rising tide' incidents such as pandemic influenza, and Chemical Biological Radiological and Nuclear (CBRN) incidents. All can involve children and their needs must be considered in planning.

Some areas of planning required specifically for children include:

- capacity of the emergency department or other services to deal with large numbers of children
- triage - an understanding of age specific physiological variables
- equipment availability
- numbers and availability of paediatric trained personnel
- availability of specialist units (e.g. paediatric burns or paediatric intensive care beds)
- networking with other healthcare organisations to provide cohesive services
- safeguarding and care of unaccompanied children
- consideration of the family unit
- psychological support for children and staff

Preparation

In responding to a major incident, the roles and responsibilities of the acute healthcare organisation are described in the DH publication *Emergency Planning Guidance*.⁸⁵ Regarding children, the organisation should:

- provide a safe and secure environment for the assessment and treatment of children
- ensure staff are equipped to assess the severity of injuries in children
- provide decontamination facilities and suitable clothing for children who self present
- ensure less seriously injured children are reunited with family members as soon as possible, and are protected from publicity
- ensure that notification of attendance is communicated to the primary care team, and relevant hospital staff, so that follow-up arrangements can be made
- provide a safe and secure environment for uninjured children or those accompanying ill or injured adults, being mindful of safeguarding vulnerable individuals
- provide psychological support for all groups of children and staff affected by a major incident

Major incident exercises

Major incident exercises should involve a proportionate number of children to adults (usually 1:4), but will depend on the incident – some are almost entirely paediatric, such as an incident involving a school. Major exercises involving children can be very rewarding, but additional measures must be taken when children participate:

- health and safety of children is paramount; particular problems in major incident exercises may be hypothermia and a requirement to ensure the environment is safe
- the media must be controlled and the privacy of children respected
- safeguarding advice must be sought
- children should be valued in giving feedback in their own right; their experience of the proceedings will be unique and should be acted on appropriately

Standards

1. All healthcare organisations ensure children are included in major incident plans and are involved routinely in appropriate major incident exercises
2. In establishing a local network of hospitals, statutory agencies and other services, children are specifically considered

10. Death of a child

The sudden and unexpected death of a child or young person can have a devastating effect on the family and is challenging for all involved. All parents will react individually and many will feel overwhelmed. Many different feelings may be experienced in an emergency situation and immediately following the death of a child – anger, outrage, utter disbelief, guilt, blame and complete sadness. At such a difficult time families need guidance, information and honest communication. Staff also need support in managing the situation and helping families. Recognising the impact the death of a child has on professionals is essential. Good communication and coordination between all professionals is vital in order that families know what is happening and are able to be involved as far as they are able and encouraged to make informed decisions.

Depending on the nature of the child's condition and death, whether from accident or illness, there are a number of legal requirements that need to be met. In particular, in an emergency department, the processes that must be followed when there is an unexpected death.

An expected death is one that is anticipated in the near future where there has been a period of prolonged illness identified as terminal. In such cases it is always best to discuss with the paediatrician leading on the child's care. An unexpected death is defined as one that is not anticipated as a significant possibility 24 hours beforehand. Working Together to Safeguard Children, 2010

In the case of unexpected death there are procedures that must be met including reporting to the coroner, involvement of the designated paediatrician on call for unexpected deaths and the rapid response team, a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. See the DfE publication *Working Together to Safeguard Children*.⁸⁶

Other legal requirements encompass verification of the fact of death, certification and notification of death. There should be clear policies and guidelines in place to support staff in understanding and completing these procedures. It is good practice for emergency departments to have a checklist of tasks, which can be complex and wide-ranging. A useful resource is the recently published *Care of the Child after Death* (Children's Hospices UK 2011).⁸⁷

If a child has died unexpectedly at home they should normally be taken to the emergency department and should not be taken directly to the mortuary; resuscitation should always be initiated unless clearly inappropriate. The Local Child Death Overview Panel (England) / Significant Case Review Committee (Scotland) / National Child Death Review Panel (Wales) will advise on policies and procedures that should be in place, including the Human Tissue Act.

If a child is being resuscitated, parents should be allowed to stay with them if they wish and if appropriate, but will need to be informed of all that is happening. It is important to recognise that it is an individual choice whether to stay in the emergency department or not, and not to assume that all parents would want this. An experienced member of staff must be identified to support them and explain the situation to ascertain their wishes.

Whether the child has died at home or within the department, talking to parents and breaking bad news should be managed sensitively, honestly and clearly. There are many resources available that offer guidance and support outlining key steps and principles in communicating with parents.

'Breaking bad news' guidance should be available to support all staff. The way in which bad news is given is an important factor in how it is received, understood and dealt with. It is important that health professionals receive education and training to develop the skills to break bad news effectively.⁸⁸ There should be a designated room which is appropriately furnished and equipped for staff to discuss information with families. Families should have access to support services including bereavement support e.g. social workers, chaplains and counsellors.

Recognising the importance of an individual's spiritual, cultural and family beliefs and values should be considered in all communication. It is best to always ask families how we should care for them.

Once a child has died there are a number of decisions that a family can be involved with and it is important for them to be in control as far as possible. They may wish to spend time touching or cuddling their child. Supporting families to care for their child after death and encouraging them to be involved is essential. Depending on the circumstances of the death parents may wish to take their child home or to a hospice where facilities are available to support the family. This should be discussed with a bereavement support professional or the hospice family/bereavement support team and with the coroner if applicable.

The possible effects of the death of a child or young person can be far reaching and will impact on wider family and friends. It is important to identify early support for all those affected by a death and guide the family to appropriate resources and support services to help in the days, weeks and years to come. Before leaving the department, parents should be provided with sufficient information to understand all that they need to know in particular the legal and regulatory requirements for example registering the death. This should include information about the involvement of a rapid response team for unexpected death.

They should also be given information about how to seek support and advice. An appointment with the hospital bereavement support officer should be made for the next 24-48 hours. Such professionals are trained and skilled in supporting families and identifying any complications experienced through grief and loss.

The parents or carers should also be offered an appointment to see a relevant consultant, in order to explain the medical facts and offer support at an appropriate interval (often between one and three months after the death).⁸⁹ This also provides valuable feedback to the emergency care setting on the handling of the situation and their support of the family.

Support of staff is essential in managing the death of a child and training and education is important in preparing staff for caring for bereaved parents. Opportunities for debrief, personal reflection and supervision should be available for all staff. Whether individual or group supervision these should be conducted to maximise learning and support any changes to practice that will benefit the department and the care of families.

Further support for staff can be found thorough the Child Bereavement Charity, Winston's Wish and Together for Short Lives.⁹⁰

Standards

1. Local checklists based on national recommendations are used in all emergency care settings
2. All children dying unexpectedly are taken to the emergency department unless there is a need to preserve a crime scene
3. Parents witnessing resuscitation are supported by an experienced member of staff
4. The consultant paediatrician on call is advised as soon as possible about an unexpected child death
5. Parents are offered an appointment to see the bereavement counsellor swiftly and a relevant consultant at a suitable time interval
6. There is co-operation with the Rapid Response Team and Child Death Overview panels

11. Information systems and data analysis

Information systems

Emergency care information systems should provide basic demographic and episode-related information, facilitate good practice, and minimise the administrative burden on clinical staff. They should meet the needs of patients, clinicians, managers, commissioners and regulators and, increasingly, ensure good quality indicators.

The system should encompass, or at least be able to link with, all sites in the local network which provide urgent care to children. All current health care of children should be available on the system, to facilitate appropriate communication and follow-up. Providers should also ensure that all episodes of care of children are available, including, for example clinics in the community, maternity, fracture and genitourinary, visits to other health professionals such as physiotherapy and all mental health and ambulance episodes.

Representatives of the emergency care settings in the four countries need to engage with national Information Technology policy and programmes to influence the national agenda and with local service providers to influence the design of their local systems.

Functions of an ideal information system should include

- demographic data (name, address, date of birth)
- contact telephone numbers (including mobile)
- name of person with parental responsibility
- name of person accompanying child
- mode of transport to hospital
- name of nursery/school/college, if applicable
- name of GP/midwife/health visitor/school nurse, as applicable
- presenting complaint
- previous attendances to the same emergency department
- the location, if the presentation is for an injury, for injury prevention surveillance
- a communication system, including linkages to the hospital's systems for recording hospital episodes, and regional/national data, as well as an automated process for informing the child's primary care team of the attendance
- a real-time service delivery function, such as patient tracking within the emergency care setting, electronic ordering of tests, prescribing, etc
- real-time clinical support, including alert categories, linkages to individual care plans, and a method of identifying previous attendances and frequent attendees
- a reporting system with good clinical coding, the ability to break down patient categories (e.g. by age), sufficient information to facilitate audit and clinical governance within the emergency care setting (e.g. national recommendations, and injury surveillance), information about service provision (e.g. timings of the patient journey, and staff performance statistics) and quality outcome measures (national such as CEM analgesia use in trauma as well as locally defined clinical outcome measures that can monitor and drive local service improvements)

Ideally, the system should also include, or be linked to, other sources of information (e.g. the Toxbase⁹¹ website, local clinical or operational guidelines, decision support software, online medical information services, and search engines), and be able to link to clinicians' personal CPD data.

Injury surveillance

Injuries are the most common cause of death and preventable morbidity in the population below the age of approximately 30 years. Injury prevention is one of the least well researched, and underdeveloped elements of children's services. Knowledge of the epidemiology of injury is critical to prevention. Information about accidents in the local area should be available from the emergency department database, and can be used to inform local government policy, the media, and the police, within the limits of patient confidentiality. Advice is available through the DH website.⁹²

The Trauma Audit and Research Network (TARN) is the recommended method of assessing the quality of trauma care, and outcomes following severe injury.⁹³ The CEM national audit of use and timeliness of analgesia in children with injuries is another important quality audit measure.⁹⁴

Emergency and urgent care quality indicators

In Scotland, Wales and Northern Ireland, development of clinical quality indicators for urgent and emergency care are at an early stage. The DH clinical quality indicators for emergency departments in England were introduced in April 2011 and replace the less sophisticated four hour target for arrival and discharge.⁹⁵ These are a useful basis for reviewing care provided although require interpretation for use in children. Definitions are set out in a related document.⁹⁶

'Good' care will invariably satisfy four criteria:

1. Patient-focussed with reports of good experience
2. The best health outcomes with minimal risk
3. Timely care in the best location
4. Correct first time

The indicators apply to patients of any age attending emergency departments in England and, in general, the indicators work for children as well as adults. Children in the emergency department represent a distinct group with differing presentations and management to adults. The focus on fever in the children under one year is especially welcome.

It is likely that unplanned re-attendance rates for children, especially for children less than 5 years, will be appropriately higher than adults due to the evolving nature of childhood illnesses. Adult and paediatric rates can be usefully monitored separately and ideally the re-attendance rates for under 5s should be monitored as a subgroup of 0-16 years.

A template for a patient survey for urgent and emergency care in children from DH/RCPCH Patient Related Experience Measures (PREMs) is available to help better understand care from children's experience and perspective.⁹⁷

Time to initial assessment for those arriving by ambulance as a proxy for likely 'majors' patients is not as relevant to children's emergency care as many of the sickest children are brought directly by their parents.

The indicator for 'consultant sign off' 24 hours a day remains a challenge for patients of all ages. Emergency medicine senior doctors reviewing children will need to be confident and competent in risk-assessing the sick child.

Further work in refining the national urgent care clinical dashboard is ongoing and will include children and young people. Such clinical dashboards have been proven to reduce pressure and improve quality of urgent and emergency care with locally devised systems and should be encouraged.^{98 99}

Research in paediatric emergency medicine

Emergency care settings of any size and ambulance providers can participate in, or organise, research studies. This should be regarded as a core activity, as there is a poor evidence-base for many aspects of paediatric emergency medicine. Emergency medicine has been identified as an important area of development by the National Institute for Health Research (NIHR) and resources are being increasingly identified to drive and support research in key areas. The Medicines for Children Research Network Clinical Studies Group in Paediatrics¹⁰⁰ includes paediatric emergency medicine and is involved in evaluating new research as well as identifying research opportunities in acute paediatrics.

Departments should share good practice, and take part in research projects, using the recently developed research networks. These include the Medicines for Children Network,¹⁰¹ The College of Emergency Medicine¹⁰² and the British Association of General Paediatrics Research Network.¹⁰³ Increasingly research networks are also inviting suggestions for key research questions relevant to pediatrics.

Standards

1. The needs of patients, clinicians, managers, service planners/commissioners and regulators are defined, and used to inform the development of emergency care setting information systems
2. Emergency care setting staff participate in the national information technology agenda and engage proactively to design local systems
3. There is a minimum dataset which incorporates the specific needs of children
4. Emergency care setting information systems link up with other health information systems, so that data on all local health service contacts are available with the emergency care setting
5. Injury surveillance data is collected and accessible as appropriate
6. Hospitals subscribe to the Trauma Audit and Research Network (TARN) to assess their own outcomes for patients with major trauma as well as national audits such as CEM analgesia in children with injuries
7. All providers of urgent and emergency care monitor the care provided for children using nationally defined indicator sets and use this, and additional data, when planning service improvement and proposing further quality indicators
8. Emergency care settings utilise the resources of research networks to participate in and plan research projects

Appendices

Appendix 1

Abbreviations

APLS	Advanced Paediatric Life Support
ATLS	Advanced Trauma Life Support
CAMHS	Child and Adolescent Mental Health Services
CEM	College of Emergency Medicine
CQC	Care Quality Commission (formaly Healthcare Commission)
CPD	Continuing Professional Development
DfE	Department for Education (England)
DH	Department of Health (England)
ECP	Emergency Care Practitioner
ED	Emergency Department
ENP	Emergency Nurse Practitioner
EPLS	European Paediatric Life Support
FEN	Faculty of Emergency Nursing
GP	General Practitioner
GMC	General Medical Council
ICU	Intensive Care Unit
JRCALC	Joint Royal Colleges Ambulance Liaison Committee
MIU	Minor Injuries/Illness Unit
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NSF	National Service Framework
ODP	Operating Department Practitioner
PA	Physician's Assistant
PALS	Patient Advice and Liaison Services
PIC	Paediatric Intensive Care
PICU	Paediatric Intensive Care Unit
PILS	Paediatric Intermediate Life Support
PLS	Paediatric Life Support
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RCPCH	Royal College of Paediatrics and Child Health
RN(C)	Registered Nurse (Children)
SSPAU	Short Stay Paediatric Assessment Unit
SUDI	Sudden Unexpected Death in Infancy
UCC	Urgent Care Centre*
WIC	Walk in Centre

* In this document, the term Urgent Care Centre includes NHS walk-in centres and minor illness/injury centres.

Appendix 2

Equipment list for emergency care settings.

Arrangements for access to and the use of these items should be familiar to all staff and checked regularly. Age and weight-based calculating tools, such as emergency charts or tapes, should be available to assist in the selection of equipment and drug doses.

General Items	In ED		Emergency care settings	
	Essential	Desirable	Essential	Desirable
Dry white board and markers	•			
Advanced Paediatric Life Support algorithms	•		•	
Organized emergency trolley	•		•	
Printed drug doses / tape	•		•	
Weighing scale	•		•	
Heating source (for infant warming)	•			
Clock	•		•	

Monitoring Equipment	In ED		Emergency care settings	
	Essential	Desirable	Essential	Desirable
ECG monitor & defibrillator with paediatric paddles 0–400 joules and hard copy capabilities	•		•	
Pulse oximeter (adult / paediatric probes)	•		•	
Noninvasive blood pressure monitoring (infant, child, adult cuffs)	•		•	
Rectal thermometer probe (28–42°C)	•			•
Otoscope, ophthalmoscope, stethoscope	•		•	
Cardiopulmonary monitor	•			•
Invasive arterial and central venous pressure transducers & connections	•			
Portable capnograph	•			
Arterial / capillary blood glucose monitor	•		•	
Access to blood gas machine	•			
Access to 12 lead ECG	•		•	

Airway Control/Ventilation Equipment	In ED		Emergency care settings	
	Essential	Desirable	Essential	Desirable
Bag-valve-mask device: paediatric (500 mL) & adult (1000 / 2000 mL) with oxygen reservoir bags	•		•	
Infant, child, and adult masks	•		•	
Oxygen delivery device with flow meter	•		•	
Clear oxygen masks, standard and non-rebreathing (neonatal, infant, child, adult)	•		•	
Nasal cannulae (infant, child, adult)	•			
Oral airways (sizes 0-5)	•		•	
Suction devices-catheters 6-14 FG Yankauer-tip	•		•	
Nasal airways (infant, child, adult)	•			
Nasogastric tubes (sizes 6-16 fr)	•			
Laryngoscope handle and blades: Macintosh curved 2,3; Robertshaw/Seward straight 1,2	•			
Endotracheal tubes + tape for securing: uncuffed (2.5-5.5), cuffed (3.0-9.0)	•			
Stylets for endotracheal tubes (paediatric, adult)	•			
Lubricant, water soluble	•			
Magill forceps (various sizes)	•			
Laryngeal masks (size 0-3)	•			•
Tracheal guide	•			
Tracheostomy tubes (Sizes 3-6mm ID)		•		
Oxygen blender	•			
Ventilators (capable down to 5 Kg Infant)	•			
Chest drain set	•			
Cricoidotomy set	•			

The equipment in the resuscitation area of any emergency care setting should include end-tidal CO₂ and invasive blood pressure monitoring.

Vascular Access	In ED		Emergency care settings	
	Essential	Desirable	Essential	Desirable
Butterflies (19–25 gauge)	•		•	
Needles (18–27 gauge)	•		•	
Intraosseous needles	•		•	
Catheters for intravenous lines (16–24 gauge)	•		•	
IV administration sets and extension tubing with calibrated chambers	•		•	
Paediatric infusion pumps	•			
Syringe drivers	•			
I.V. fluids	•		•	
Lumbar puncture set		•		
Urinary catheters: Foley 6–14 Fr	•			
Fracture immobilisation	•			
Cervical collar (hard) various sizes	•		•	
Head blocks & tape	•		•	
Femur & pelvic splint	•			
Extremity splints		•		

Appendix 3

Paediatric resuscitation training and updating

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

STAFF GROUP	Appropriate minimum training
MEDICAL STAFF	
Consultant who may be on call for acute paediatrics, ED, ICU/Anaesthesia or PICU	Advanced Life Support
ST3-8 in acute paediatrics, ED, ICU/ Anaesthesia or PICU	Advanced Life Support
ST1-2 in acute paediatrics, ED or ICU/ Anaesthesia	One day Paediatric Life Support
Medical staff (all grades) caring for children in settings other than acute paediatrics and ED	One day Paediatric Life Support
NURSING STAFF	
Registered Nurse (Band 5) in emergency care setting	One-day Paediatric Life Support (Yearly update)
Registered Nurse (Band 6) in emergency care setting	Advanced Life Support (APLS or EPLS) & One-day Paediatric Life Support (Yearly Update)
Senior Nurses (Band 7) in emergency care setting	Advanced Life Support (APLS or EPLS) & One-day Paediatric Life Support (Yearly Update)
Autonomous practitioners	Advanced Life Support (APLS or EPLS) & One-day Paediatric Life Support (Yearly Update)
Health care assistants	Basic Life Support

NOTES:

Updates: Basic Life Support should be updated yearly. Advanced resuscitation skills should be refreshed every three/four years. Please also refer to the recommendations of any providing agencies.

The expected level of Advanced Life Support training can be met by courses such as APLS or EPLS. However, more may be expected from already highly qualified practitioners, so training should be tailored to the individual and identified by formal yearly appraisal. For example, simulation training & clinical attachments may be required.

Paediatric Life Support training (basic or one-day, according to the individual's role) should be undertaken within the first 20 days of working with acutely ill children. This training should be transferable between posts (and hospitals). Advanced Life Support should be of at least 8 hours duration in total and include both lectures in recognition of ill children and practical skills training in defibrillation, basic airway management and intraosseous access. Assessment of competence should be undertaken and evidence of competence should be documented.

Appendix 4

Terms of reference and membership of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings

- a. To act as an expert advisory group on the emergency care of children.
- b. To influence policy development proactively at national level.
- c. To respond reactively to consultation documents relevant to the emergency care of children.
- d. To support practitioners and inspection agencies in the improvement of services by developing standards and measurements of those standards.
- e. To identify and disseminate best practice.

Membership

Dr Stephanie Smith	Chair
Dr Jason Barling	RCPCH member
Mrs Sally Sweeney Carroll	RCPCH Patients' and Carers' Advisory Group
Dr John Criddle	Association of Paediatric Emergency Medicine
Mrs Sue Eardley	RCPCH Head of Health Policy
Dr Agnelo Fernandes	Royal College of General Practitioners
Mr Jason Gray	Royal College of Nursing
Dr Steve Halford	College of Emergency Medicine
Miss Susie Hewitt	College of Emergency Medicine
Dr Ian Jenkins	Royal College of Anaesthetists
Dr Fiona Jewkes	Joint Royal Colleges Ambulance Liaison Committee
Dr Omnia Marzouk	RCPCH, Chair CSAC Paediatric Emergency Medicine
Mr Bruce Okoye	British Association of Paediatric Surgeons
Dr David Shortland	RCPCH Vice President for Health Services
Dr Martin Smith	British Association of Emergency Medicine
Co-opted Advisors	
Dr Ted Wozniak	Department of Health (England) Professional Advisor in Paediatrics
Mr Martin Smith	Senior CAMHS Lecturer – Middlesex University Community Consultant CAMHS Nurse – Tavistock Clinic
Helen Bennett	Care Development Manager, Together for Short Lives (formerly Children's Hospices UK)
Laura Green	RCPCH Project Co-ordinator

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