NHS
Yorkshire
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NHS Trust

Paediatric Care Policy (Excludes NHS 111)

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V2.2	21/08/14	Steven Dykes	D	Change to policy to cover Operational, Clinical and Training responsibilities and issues
V2.3	19/08/16	Steven Dykes	D	Change in Clinical Practice guideline PCR not PRF
V3.0	25/08/16		A	Clinical Governance Group
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V4.1	Feb 18	Risk Team	A	Document Formatted – New visual Identity

A = Approved D = Draft

Document Author = Associate Medical Director – Quality

Associated Documentation:

- Policy and Procedure for Safeguarding Children and Young People
- Policy for the management of Domestic Abuse
- Policy for Identifying and Acting Upon National Clinical Guidance
- Procedure for the management of JRCALC guidance
- Procedure for the management of NICE guidance
- Resuscitation Policy
- Policy for the Conveyance and Non-Conveyance of Patients
- Managing Medical Devices Policy
- Obstetric Care Policy

Staff Summary

A child is defined as anyone who has not yet reached their 18th birthday (Children's Act 1989)
Staff will follow the processes laid down within JRCALC guidelines for the assessment, diagnosis and treatment regimens for all paediatric patients.
Recognising and acting upon the signs and symptoms of a seriously ill child is much more important than reaching the correct diagnosis.
Analgesia should normally be administered in an incremental way, considering timeliness, effectiveness and potential adverse events.
All children in cardiac arrest must be conveyed to hospital unless they have a condition that is unequivocally associated with death or if Police request that the body remain on scene. All children must be taken to the ED and NOT the mortuary. (Hypostasis and rigor mortis are not considered unequivocal death in young children)
All children under the age of two years should be conveyed to a health care facility.
All children aged 2 to 17 (up to the date of their 18th birthday) should be conveyed to health care facility or referred to a health care professional who accepts the duty of care from the point of referral
The protection of children from harm is the responsibility of everyone. It is essential that whenever an individual has concerns about whether a child is suffering, or is at risk of suffering significant harm, that they share their concerns using the YAS Policy for Safeguarding Children and Young People or the YAS Policy on management of domestic abuse
Staff should indicate during their PDR (personal development review), whether they require update training in paediatric emergencies or Safeguarding Level 2. This can be facilitated via the Clinical Development Manager or if new skills are needed via the Organisational Effectiveness and Education Department.

1.0 Introduction

1.1 This policy details the processes by which Yorkshire Ambulance Service NHS Trust (YAS) will effectively implement and manage the provision of paediatric care

1.2 A child is defined as "anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people, does not change his or her status or entitlement to services or protection under the Children's Act 1989 (Working Together 2013)

1.3 This policy does not apply to staff working in NHS 111.

1.4 This policy does not apply to staff working in the EMBRACE transport service. Clinical care and governance is provided by the Sheffield Children's NHS Foundation Trust.

1.5 The care for all paediatric patients will be delivered in accordance with guidance fromAACEthrough JRCALC guidelines, NASMeD, the National Service Framework for Children, NICE (National Institute for Clinical Excellence), Royal College of Paediatrics and Child Health (RCPCH) and CQC (Care Quality Commission)

1.6 This policy is designed to be read in conjunction with other Trust policies which are relevant to paediatrics, including:

- Policy and Procedure for Safeguarding Children and Young People
- Policy for the management of Domestic Abuse
- Policy for Identifying and Acting Upon National Clinical Guidance
- Procedure for the management of JRCALC guidance
- Procedure for the management of NICE guidance
- Resuscitation Policy
- Policy for the Conveyance and Non-Conveyance of Patients
- Managing Medical Devices Policy
- Policy on Obstetric Care

2.0 Purpose

2.1 To ensure the delivery of safe and effective care to children

2.2 To ensure that all staff are trained appropriately in the delivery of care to children

2.3 To ensure that clinicians have access to appropriate paediatric equipment

3.0 Process

Delivery of Care

3.1 Staff will follow the processes laid down within Clinical Practice Guidelines for the assessment, diagnosis and treatment regimens for all paediatric patients.

3.2 These cover the following areas:

- Medical Emergencies in Children
- Trauma Emergencies in Children
- Anaphylaxis and Allergic reactions in Children
- Asthma in Children
- Burns and Scalds in Children
- Convulsions in Children
- Glycaemic Emergencies in Children
- Overdose and Poisoning in Children
- Child Basic/advanced Life Support
- Newborn Life Support
- Child Foreign Body Airway Obstruction
- Dealing with the Death of a Child (including sudden death in infancy SUDI)

3.3 Recognising and acting upon the signs and symptoms of a seriously ill child is much more important than reaching the correct diagnosis.

3.4 Recognition of the seriously ill or injured child involves the assessment of the child's airway, breathing, circulatory and neurological systems. If any of these signs are present, the child must be transferred to hospital as a time critical patient and a pre-alert made to the receiving hospital. On scene time must be kept to a minimum

Analgesia

3.5 The Trust works to the guidance as detailed in Clinical Practice Guidelines in the management of pain in children and recognises that all children in pain need analgesia, regardless of age or situation.

3.6 Analgesia should normally be administered in an incremental way, considering timeliness, effectiveness and potential adverse events.

3.7 Pain management should always include the non-pharmacological methods of treatment as a starting point and may be administered by all attending staff. However it may be apparent from the assessment that a stronger analgesia is necessary from the outset and, therefore the appropriately trained member of staff would need to administer it.

3.8 Non pharmacological methods include management aspects such as psychological, dressings and splints.

3.9 Pharmacological methods include topical analgesia, oral analgesia, and inhaled analgesia, parental and enteral analgesia. These methods are administered by appropriately trained staff, and according to the guidance in the Clinical Practice Guidelines.

Cardiac Arrest

3.10 Resuscitation should be attempted in all cases unless there is a condition unequivocally associated with death or a valid advance directive, limitation of treatment arrangement (LOTA) or DNAR is in place. Hypostasis and rigor mortis are not considered unequivocal death in young children

3.11 All children in cardiac arrest must be conveyed to hospital unless they have a condition that is unequivocally associated with death or if Police request that the body remain on scene. All children must be taken to the ED and NOT the mortuary.

3.12 The aetiology of cardiac arrest in children is often different to adults, and is much more likely to occur as a result of unrecognised or prolonged hypoxia. The primary requirements are good quality basic life support, good oxygenation, fluid if required and a minimum of on-scene time with rapid transport to the Emergency Department

3.13 Paediatric intubation has been withdrawn by Yorkshire Ambulance Service. A stepwise approach to opening and maintaining the airway should be adopted.

Febrile Illness in Children

3.14 Sick children are notoriously difficult to assess except for times when they are obviously very ill or injured, with grossly deranged vital signs. In critically ill children, temperature is not routinely recorded as part of the ABC approach as it delays treatment without altering management.

3.15 Temperature should however be measured in the less ill child, where it forms part of the picture of their illness and is essential in informing decision

making. Staff must use the NICE Traffic Lights Clinical Assessment Tool in these children, especially when considering referral to alternatives to the Emergency Department.

Conveyance and Non conveyance

3.16 All children under the age of two years should be conveyed to a health care facility. If the parent or carer refuses transport of the child then referral to an appropriate health care professional must be made (e.g. GP or health visitor). Enquiries must be made with social services or the GP prior to leaving the scene.

3.17 All children aged 2 to 17 (up to the date of their 18th birthday) should be conveyed to hospital or referred to a health care professional who accepts the duty of care from the point of referral

3.18 However there may be occasions where the child or parent/care does not wish the child to travel following assessment. For any child that is not conveyed even where they refuse treatment the ambulance clinician MUST make an immediate referral to another healthcare professional who can assume responsibility for their on-going care. It must not be left for the parent/carers to contact their own GP for follow up.

3.19 Emergency Care Practitioners who have received specific training in the management of children under the age of two years may decide to not to convey following assessment. However, in all cases a discussion with the patients primary care provider or if not possible the Social Services must take place and be clearly documented

Safeguarding Children and Young Adults

3.20 The protection of children from harm is the responsibility of everyone. It is essential that whenever an individual has concerns about whether a child is suffering, or is at risk of suffering significant harm, that they share their concerns using the YAS Policy for Safeguarding Children and Young People or the YAS Policy on management of domestic abuse.

3.21 Staff may also identify and report concerns re the safety/welfare of an unborn child following contact with the pregnant patient or other members of the pregnant patient's household. Concerns may be an incident witnessed, behaviours or environments observed or statements or threats made, including suspected or actual fabricated or induced illness (FII) that cause staff to feel a children is at risk of harm, abuse, neglect or ill-treatment.

4.0 Training expectations for staff

4.1 All paediatric training will adhere with the current clinical guidelines issued by AACE, in consultation with Clinical Practice Guidelines which reflects the minimum national standards that YAS expect all staff to adhere to

4.2 All staff responding to incidents involving paediatric emergencies or urgent details will receive the relevant level of paediatric training on their core training course as outlined in

the course learner outcomes, awarding body objectives or module indicative content. These are held by the Head of Education and Standards and dictate the programme of education for all core courses.

4.3 Staff will receive refresher/update training via the Clinical leadership scheme, which will be monitored through the completion of a clinical competency portfolio and signed off by the Clinical Supervisors and Clinical Development manager and quality assurance checked by the Organisational Effectiveness and Education Department.

4.4 Whenever there is a major change in an associated clinical guideline, this will be issued via Clinical Update, the Clinical Development manager, Clinical supervisor, or through update training. The method used will be dictated by the nature or complexity of the changes.

4.5 Staff should indicate during their PDR (personal development review), whether they require update training in paediatric emergencies or Safeguarding Level 2. This can be facilitated via the Clinical Development Manager or if new skills are needed via the Organisational Effectiveness and Education Department.

4.6 It will be the responsibility of the relevant line manager to ensure that each individual has the required release from duty and attends the programme of study.

5.0 Implementation Plan

5.1 The latest approved version of this Policy will be posted on the Trust Intranet site for all members of staff to view. New members of staff will be signposted to how to find and access this guidance during Trust Induction.

6.0 Monitoring compliance with this Policy

6.1 This policy will be reviewed on a 2 year basis. Ensuring the compliance and effectiveness of this policy is continuous and may evoke revision within this period if found to be necessary.

Standard	Monitor
Process for monitoring the organisational duties	Organisational and individual duties have been assigned Monitoring and compliance of duties will be via the Clinical Governance Group Deficiencies in the applications of and/or adherence to this policy will be reported to the Clinical Governance Group who will note them in their minutes together with any corrective action(s) that need to be taken to ensure compliance. Progress of these actions will be reviewed at subsequent meetings.
Process for managing the organisations expectations in relation to staff training as identified in the training	All staff identified as requiring paediatric training will undergo initial training linked to course learner outcomes agreed with the Clinical Directorate or awarding body.

needs analysis	All staff undertaking core training with paediatric care as an element will be added to the OLM (Oracle Learning Management) data base which will be monitored by the Clinical Education Coordinator and reported through the Clinical Governance Group. Staff requiring update training will be coordinated and added to the OLM database by the Clinical Education Coordinator and reported via the Clinical Governance Group. Ongoing monitoring of compliance will be via the Clinical Leadership system and monitored through the achievement of the clinical competencies within the clinical competency portfolio, and held on the OLM system. Any required update training will be via Organisational Effectiveness and Education Department.
Process for monitoring the minimum standards of Paediatric training which reflect national guidelines	This will be monitored through the Clinical Leadership Framework and the achievement of observed practice and achievement of operational competencies held on the OLM system

Appendices

Appendix A - Roles & Responsibilities

Trust Board

The Trust Board have overall responsibility to ensure all aspects of the policy on paediatric care are implemented and adhered to. They will be required to gain assurance that the policy is being implemented and adhered to.

Clinical Directorate

The Clinical Directorate will ensure that best practice is followed and work with the Organisational Effectiveness and Education Department ensuring best practice and current evidence based practice is utilised in the training of paediatric care.

The Clinical Directorate will be responsible for ensuring that the care provided to children is audited

The Clinical Directorate will review the minimum equipment list on a yearly basis at the Clinical Governance Group. Any changes will be communicated to the Vehicle and Equipment Group. (Appendix 1)

Organisational Effectiveness and Education Department

The Organisational Effectiveness and Education Department will oversee and provide all training requirements regarding paediatric care.

They will develop all learner outcomes and implement them for all paediatric care courses or paediatric elements of core courses delivered within YAS.

They will implement changes in line with best practice following discussions or direction from the Clinical Directorate.

Operations Directorate

The Operations Directorate will be responsible for the delivery of paediatric care. The Operations directorate will have a mechanism in place to monitor all clinical operational staff ensuring that they deliver the appropriate level of care to paediatric patients.

They will link in to both the Clinical Directorate and Organisational Effectiveness and Education Department, highlighting any areas of concern regarding paediatric care management. They will ensure staff are appropriately trained to provide good quality care to children

They will ensure that a process of communication with the Clinical Development Manager and Clinical Supervisors is in place to ensure the dissemination of changes to practice with paediatric care management.

Support Services Directorate

The Support Services directorate shall ensure that front line clinicians are equipped with appropriate equipment to care for children as recommended by the minimum equipment guidelines (Appendix 1)

The Support Services and Clinical directorate will review the minimum equipment list for compliance on a yearly basis

The Vehicle and Equipment Group will coordinate the assessment and potential roll-out of any new equipment as directed by the Clinical Directorate.

Individual Duties

Chief Executive

The Chief Executive is responsible for ensuring that resources and mechanisms are in place for the overall implementation, monitoring and review of this policy.

Executive Medical Director

Has overall responsibility for the implementation of this policy in accordance with the Clinical Practice Guidelines and for ensuring that all staff deliver care in accordance with this policy.

The Executive Medical Director may devolve some duties to other roles within the Clinical Directorate.

Head of Education and Standards

Is responsible for ensuring that each core course has an appropriate level of paediatric education embedded within the syllabus, to meet the area of responsibility for that role. Some of this responsibility will be devolved to the Education Commissioning and Assurance manager within the Organisational Effectiveness and Education Department.

Will ensure that learner outcomes are derived from best practice in line with Clinical Practice Guidelines.

To liaise with the Executive Medical Director regarding changes in best practice or implementation of additional/new elements to be covered in the syllabus, and paediatric equipment to be issued or carried by the Trust or on Trust vehicles or premises.

Ensuring all tutors and personnel under their supervision are competent in all aspects of paediatric care up to their level of responsibility of practice.

To evaluate and review all taught educational material on a regular basis to ensure it meets; current best practice, Trust requirements and is appropriate for its purpose.

Communicate information on the correct selection, usage and maintenance of paediatric care equipment to staff, particularly relating to actions taken, post incident reports or as part of a “lessons learned” process.

Clinical Staff

Ensure that they maintain their paediatric assessment, diagnosis and treatment skills (as appropriate) in line with their training, and skill level.

Actively manage paediatric pain appropriate to their skills, training and scope of practice. If the management of pain for a particular paediatric patient is beyond their skills, competence or

knowledge, they should promptly consider seeking advice or the attendance of a clinician with more advanced skills.

Ensure that the paediatric care policy is adhered to within their area of responsibility.

Ensure incidents involving paediatric care failure are reported to their line manager and through DATIX promptly and accurately.

Appendix B

Paediatirc kit and maternity pack July 1