Right Place, Right Time, Right Team

A review of the quality of the care provided to children needing emergency surgery

RECOMMENDATION IMPLEMENTATION SUGGESTIONS

1 RECOMMENDATION IMPLEMENTATION SUGGESTIONS

- Pathways should be written by the local providers in collaboration with the operational delivery networks (ODNs) with support from all interested parties including primary care
- Involve primary care and paediatricians in the development of local emergency surgery networks
- Make sure everyone is aware that local networks exist
- Learn from existing ODNs, or equivalent
- Encourage collaboration and forge mutually useful relationships
- Hold network-level morbidity and mortality meetings to share learning and improve service development
- Develop management plans for a given condition and agree them at a network level
- Develop formal local and network agreement to provide joint care between surgical specialties and paediatricians as needed
- Surgical specialties and paediatricians could jointly audit and review the care of children and young people admitted for emergency procedures
- Work with the ODNs to create policy and standard operating procedures (SOPs) for treatment and transfer for children and young people, regionally and locally
- Hospitals without a suitable paediatric or neonatal intensive care bed could obtain the advice of the local paediatric intensive care unit (PICU) transport team during the management of the sick or critically injured child or young person
- Specialist tertiary paediatric centres with PICU facilities should provide clinical advice and help in locating a suitable PICU bed once a referral has been made
- Establish transfer procedures with ambulance trusts/health boards to ensure that emergency transfers of children and young people with a surgical emergency are timely and utilise an age-appropriate vehicle
- Regional or network scoping exercises could be undertaken to highlight shortfalls in confidence or transfer options
- If the surgery needed is more urgent than emergency, delay it, if clinically appropriate, and with no risk to the patient, so that it can be undertaken during the day, rather than out of hours
- Identify clinicians in each trust/health board who would deliver paediatric care out of hours.

2 RECOMMENDATION IMPLEMENTATION SUGGESTIONS

- The co-ordinator role could be undertaken by:
  - A senior nurse (team leader/band 6+)
  - A senior operating department practitioner
  - A consultant anaesthetist (designated as an emergency 'troubleshooter' or co-ordinator)

And could be:

  - Someone not directly involved in the acute care of emergency patients with the respect and authority to make decisions about patient priority within the entire acute workload
  - A dedicated clinical job role
  - Co-located within the theatre team

Additional training may be required

- Hold a multidisciplinary (including scrub) handover/planning meeting at the beginning of the day with all parties who have a child booked on the emergency list. This could be led by the co-ordinator.
- The theatre co-ordinator may benefit from support from on-call staff and senior theatre clinicians, particularly at times of high demand and acuity of emergency cases
- Use local prioritisation guidelines
- Include fasting requirements on protocols for the management of children and young people who require non-elective surgery
- A real-time system to record booking and operating details with a reporting structure that highlights breaches would be beneficial – improved digital capabilities would streamline the process
- Consider using electronic records and develop systems that help to identify potential bottlenecks, gaps and reallocation
- Use digital processes to measure/compare acuity of cases booked on mixed CEPOD lists and likelihood of low acuity of children and young people being seen in a timely manner
- Incident reporting, review and action planning after any delays outside protocol times/causing harm
- Implementation of processes to present audit data to highlight delay/breach reasons, and the dissemination of this information through networks
- Use planned urgent lists for less urgent cases to manage access to emergency theatres
- Consider the discharge process, particularly post-operative needs such as physiotherapy and transition to adult services when necessary
- Untoward delays should undergo regular audit, with the results reported at governance meetings and within the network, to ensure that action is taken including escalation plans implemented
- Audit against the Royal College of Anaesthetists ACSA standards.

3 RECOMMENDATION IMPLEMENTATION SUGGESTIONS

- Develop a national consensus on the use of ‘Sip til Send’
- Revise local policy and/or audit and QI initiatives/training to implement and assess the use of ‘Sip til Send’
- Wherever possible children and young people not needing emergency surgery (e.g. foreign body, nail bed repair) should be booked on an urgent theatre list rather than being booked on the emergency CEPOD list. This will allow better planning of fasting times.
- An identified individual could have responsibility for monitoring delays and communicating with the ward/admission area to ensure that appropriate levels of nutrition are maintained
- Provide information sheets and posters for both staff and patients/families.