Peer Review standards. (GPAS non-ACSA standards)

GPAS section	GPAS reference	Evidence	Comment
1 Staffing Requirements			
2 Equipment, services and facilities			
Equipment for point of care testing of glucose, haemoglobin, blood gases and electrolytes should be readily available	2.2	Seen on visit	
Intravenous fluid management should conform to NICE guidelines, and appropriate equipment to deliver this safely should be available	2.3	Seen on visit Policy/prescribing advice	
Resuscitation drugs and equipment, including an appropriate defibrillator, should be readily available wherever children are anaesthetised	2.4	Seen on visit	
There should be ventilators available that have the flexibility to be used over a wide size and age range, and that provide accurate pressure control and positive end-expiratory pressure	2.5	Seen on visit	All ventilators which may be used for children eg remote sites
Referral pathways should be available to a paediatric psychology service	2.9	Referral forms or pathway	
Blood transfusion and diagnostic services should meet the requirements of neonates, infants and children. A massive -transfusion protocol including provision for children should be in place	2.10	Copy of protocol Seen on visit	
There should be pharmacy staff available with clinical knowledge appropriate to the local paediatric case-mix to provide advice on the management of drugs in children	2.11	Named pharmacist	
There should be access to the BNFC	2.14	Seen on visit	Paper or accessible electronic form
Analgesia guidance appropriate for children should be readily available, including protocols for pain scoring using age-appropriate validated tools	2.16	Seen on visit	
3 Areas of special requirement Critically ill children			
Individuals with responsibilities for paediatric resuscitation and stabilisation should fulfil the training requirements and maintain their competencies	3.12	Record of competencies	
In all emergency departments receiving infants and children, neonatal and	3.14	Seen on visit	

paediatric resuscitation equipment, medications (including anaesthetic drugs) and fluids should be available to prepare an infant or child for PICU transfer			
There should be immediate access to protocols for management of acute life-threatening conditions. These will often be agreed with local PICU network or PIC transport team. Protocols should include acute respiratory, cardiovascular or neurological emergencies, trauma, poisoning and major burns	3.15	Copies of protocols	
Specialist centres with PICU facilities should provide clinical advice and help in locating a suitable PICU bed	3.17	Description of the process and responsibilities	
There should be data collection for all referrals to PICU	3.18	Data	
If a patient is too sick to transfer to a hospital with a PICU or NICU prior to surgery and their current hospital has surgeons capable of operating, then transfer should occur as soon after surgery as is clinically appropriate	3.22	Discussion about surgical capabilities and management of sick surgical children. Copies of SOP	
Transfer of critically ill children			
There should be relevant written local guidelines, with telephone numbers of the receiving unit	3.25	Copy of guidelines	
Patients being transferred should normally be accompanied by a doctor with relevant competencies in the care of a critically ill child and transfer of intubated patients, including airway management skills. They should be accompanied by a suitably trained assistant	3.26	Policy for time critical transfers	
Transport services should ensure that appropriate arrangements are in place to review transfers and provide feedback to networked hsopitals	3.27	Evidence of feedback/review	
Day care procedures and anaesthesia			
A local policy on analgesia for home use should be in place, with either provision of medications, or advice to parents and carers before admission to purchase suitable analgesics. In both instances, there should be clear instructions to	3.35	Copy of policy and written instructions	

parents and carers about their regular use in the correct dose and for a suitable duration. Parents and carers should be given written instructions on administration of analgesia and know who to contact if problems arise. In addition, safe practice with medicines when children are present should be emphasised.			
Teenagers and young adults			
A person centred approach should be used to ensure that the young person is an equal partner in decisions regarding their care during the transitional period.	3.39	Policy for transitional arrangements	
Anaesthesia records from their previous care should be available for the new service (or a summary document should be provided)	3.40	Policy for the transfer or availability of records	
Health and social care managers in children's and adult's services should work together in an integrated way to ensure a smooth and gradual transition for young people	3.41	Evidence of meetings	
4 Training and education			
Anaesthetists with a substantial commitment to paediatric anaesthesia should have satisfied the higher-and advanced-level competency-based training requirements in paediatric anaesthesia of the RCoA or equivalent. It is recognised that anaesthetists involved in highly specialised areas such as paediatric cardiac and neurosurgery will require additional training that is individually tailored to their needs	4.1	Evidence of appropriate training requirements eg job spec for lead paediatric consultant anaesthetist	
All anaesthetists who provide elective or emergency care for children should have advanced training in life support for children, and should maintain these competencies by annual training that ideally is multidisciplinary and scenario based	4.2	Evidence of training records	
Anaesthetists should be aware of legislation and good-practice guidance relevant to children and according to the location in the UK. These documents refer	4.3	Discussion	

to the rights of the child, child-protection processes, and consent			
All anaesthetists must undertake at least level 2 training in safeguarding/child protection, and must maintain this level of competence by annual updates of current practice and case discussion	4.4	Record of training	
At least one consultant in each department should take the lead in safeguarding/child protection and undertake training and maintain Level 3 competencies. The lead anaesthetist for safeguarding/child protection should advise and co-ordinate training within the department, but will not have responsibility for deciding on management of individual cases	4.5	Named safeguarding lead with level 3 training	
Anaesthetists who do not have regular children's lists but who do have both daytime and out-of-hours responsibility for providing care for children requiring emergency surgery should maintain appropriate clinical skills. There should be arrangements for undertaking regular supernumerary attachments to lists or secondments to specialist centres. The Certificate of Fitness for Honorary Practice may facilitate such placements, and provides a relatively simple system for updates in specialist centres. Paediatric simulation work may also be useful in helping to maintain paediatric knowledge and skills. There should be evidence of appropriate and relevant paediatric CPD in the five-year revalidation cycle.	4.6	Discussion about department policy, use of certificate of fitness for honorary practice, appraisal requirements	
There should be funding and arrangements for study leave such that all consultants and career grade staff who have any responsibility to provide anaesthesia for children are able to participate in relevant CPD that relates to paediatric anaesthesia and resuscitation and to their level of specialty practice. Individual CPD requirements should be jointly agreed during the appraisal process.	4.7	Discussion	
The establishment of regional networks	4.8	Discussion about	

for paediatric anaesthesia should facilitate joint CPD and refresher training in paediatric anaesthesia and resuscitation. Where appropriate, joint appointments may be considered, allowing designated anaesthetists from non-specialist centres a regular commitment within a specialist centre in order to maintain and develop skills		local network	
5 Organisation and administration			
The opinions of children and young people and their families should be sought in the design and evaluation of services and future planning	5.4	Mechanism for child/family involvement	
All hospitals that provide surgery for children and young people should have clear operational policies regarding who can anaesthetise children for elective and emergency surgery. This will be based on ongoing clinical experience, the age of the child, the complexity of the surgery and the presence of any co-morbidity	5.5	Policy	
Children and young people undergoing surgery should be placed on designated children's operating lists in a separate children's theatre area. When this is not possible, children and young people should be given priority by placing them at the beginning of a mixed list of elective or emergency cases.	5.7	Evidence of list order policy	
A WHO checklist should be completed before and during all procedures and investigations under anaesthesia and sedation, if provided by the anaesthetic department. Appropriate checklists should include issues particularly pertinent to the paediatric age group such as flushing of IV cannulae prior to discharge to the recovery/post anaesthesia care unit.	5.8	Copies of checklist and recovery policies	
Hospital should review their local standards to ensure that they are harmonised with the relevant national safety standards, e.g. national Safety Standards for Invasive Procedures in England or the Scottish Patient Safety Programme in Scotland. Organisational leaders are ultimately responsible for	5.9	Discussion with managers	

implementing local safety standards as necessary			
A child centred approach should be employed whenever possible throughout the care pathway, so that there is physical separation between adult patients and children and young people in the operating department, day-unit ward and in the emergency department.	5.10	See on visit	
Access to critical care facilities			
On site ICU and HDU facilities should be appropriate to the type of surgery performed and the age and co-morbidity of patients and should be available to support the delivery of more complex post operative analgesic techniques	5.17	See on visit	
7 Research, audit and quality improvement			
Adoption of national initiatives , for example 'Hellomynameis' should be encouraged and evaluated			
Audit activity should include the regular analysis and multidisciplinary review of untoward incidents. Serious events and near misses need to be thoroughly investigated and reported to the relevant national agency in line with national requirements	7.6	Evidence of audit, M&M, SUI	
There should be ongoing audit of all children transferred between hospitals for surgery and this should be monitored by referring hospitals paediatric surgical committee. Delays should be critically examined by the regional network	7.7	Evidence of audit	
Anaesthetic research in children should be facilitated when possible and should follow strict ethical standards	7.8	Participation in national audits Evidence of appropriate training by those doing research.	
Anaesthetists who care for children and young people should be familiar with relevant patient safety issues	7.9	Discussion. How is information disseminated	
9 Patient information			

Information provided post operatively should include the safe use of analgesia after surgery and discharge from hospital, and what to do and who to contact in the event of a problem or concern. This should include telephone numbers where advice may be sought 24 hours a day Information should be clear and consistent. It should be given verbally and also in written and/or electronic form	9.3, 9.4	Copies of information leaflets. Discussion with preassesment team and ward teams	
Post menarcheal female patients should be made aware of the needs for clinicians to establish pregnancy status before surgery or procedures involving anaesthesia. Whilst obtaining and documenting this information is primarily the responsibility of the operating surgeon or paediatrician, anaesthetists may also feel it necessary to confirm that such checks have been performed.	9.7	Policy and patient information	
Consent			
Parental responsibility should be established in advance of admission, and appropriate consent procedures followed, involving the court and/or social services as appropriate	9.9	Preassessment policy	
For planned procedures, if there is doubt about parental responsibility, advice should be sought from senior hospital medical staff and/or defence organisations	9.10	Discussion	
Children may require anaesthesia for diagnostic procedures such as MRI scans. Anaesthetists should ensure that parents and legal guardians have been informed about the associated risks and common side effects of the anaesthetic.	9.13	Information leaflet and consent forms should be seen	
If withdrawing or withholding life-sustaining treatments is being considered, possible outcomes and plans should be carefully discussed and documented by the multidisciplinary team of professionals and the family/young person (as appropriate) in advance of planned anaesthesia and including the management of ‘do not attempt cardiopulmonary resuscitation’ orders.	9.14	Policy	