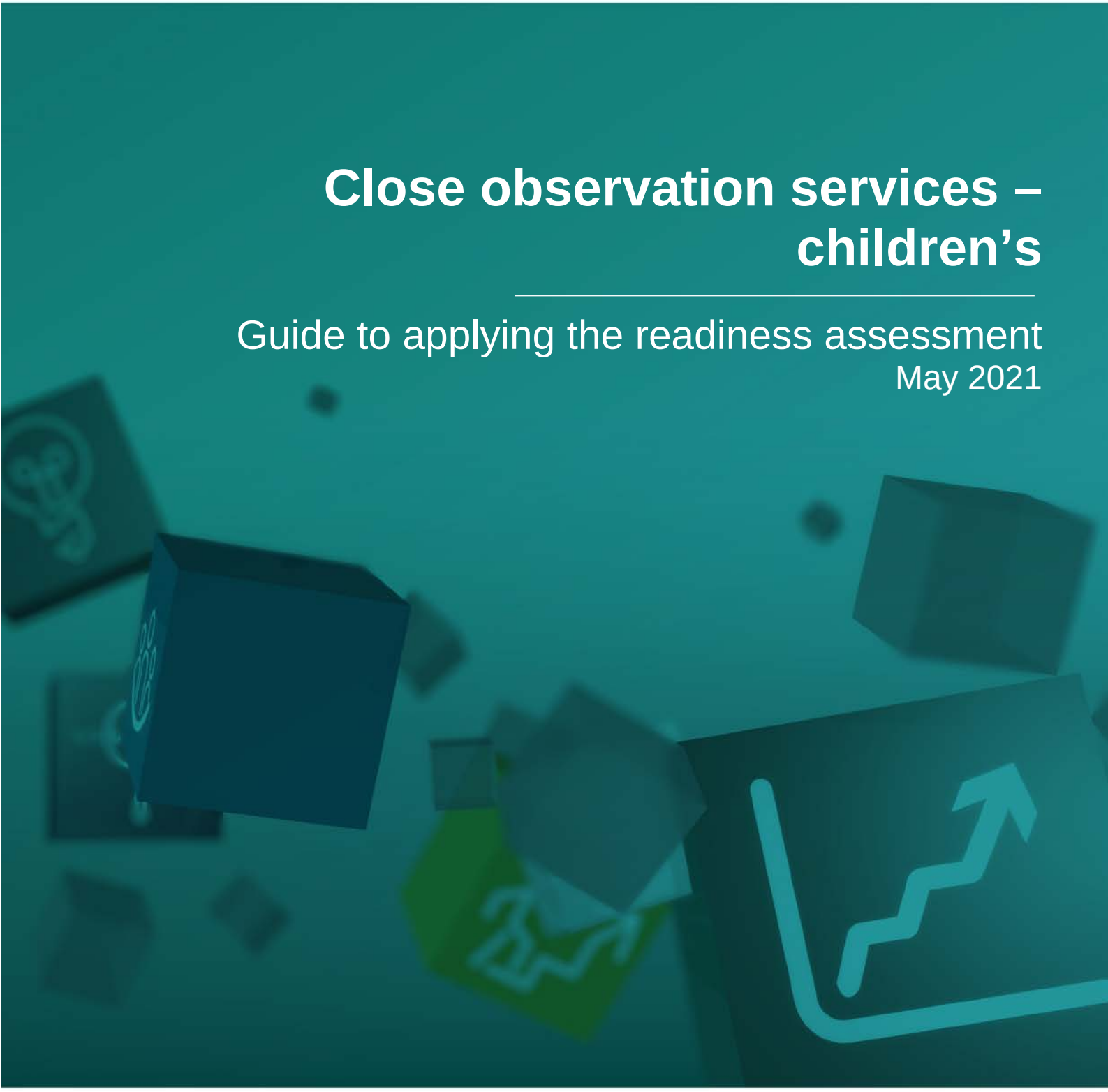
Queensland Health

Clinical **Excellence** Queensland

Close observation services – children's

Guide to applying the readiness assessment

May 2021



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Close observation services – children's: Guide to applying the readiness assessment

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Contents

Introduction

A close observation service for children provides services for children that require a level of care between a general paediatric ward and an intensive care unit. The Queensland Paediatric Critical Care Pathway Project (QPCCP Project) led the development of the Close Observation Services – Children's Clinical Services Capability Framework (COS-C CSCF) Module in 2020. The CSCF Module describes the minimum capability requirements for that service. Sites seeking to offer a Close Observation Service – Children's (COS-C) must meet the requirements of the CSCF.

Following the drafting of the COS-C CSCF Module, the QPCCP Project Team developed this readiness assessment package to guide the establishment of a new service and provide a framework for continuous improvement of the service. The package includes the Readiness assessment (Excel spreadsheet) and this Guide to readiness assessment. The package is to be read in conjunction with the CSCF Module as the documents have a different purpose. The CSCF Module describes the minimum standards for the service whereas the Readiness assessment provides an interactive mechanism to provide detailed guidance for a facility that is currently offering or preparing to establish a COS-C. The readiness assessment is suitable for use with all three levels of COS-C as described in the CSCF Module.

While the CSCF level is self-assessed in public facilities, the result is formally reported to the Queensland Department of Health. The Readiness assessment is also self-assessed by the facility but is designed to be an internal quality improvement activity and is not required to be reported or assessed by an external agency. Private facilities are licensed using the CSCF Modules rather than self-assessed however private facilities are welcome to utilise this readiness assessment to self-assess and continually improve their services should they choose to.

Purpose of the readiness assessment package

The purpose of the package is to:

- Compliment the COS-C CSCF in order to:
    - ensure provision of safe, quality care for children who require care that falls between the level of a paediatric ward and below the level of an intensive care unit
    - keep children closer to home where this is safe and clinically appropriate
    - build and maintain staff expertise to deliver care at a level between a paediatric ward and an intensive care unit.
- Assist hospital executive and administrators to understand the clinical, staffing and governance expectations of establishing and maintaining a close observation service.
- Provide practical guidance in the establishment of a new COS-C.
- Provide a mechanism to document current service provision for COS-C including actions needed for improvement, timeframes for improvement activities and individuals or group that will take responsibility for these improvement activities.

Applying the Close observation service readiness assessment package

This document has been developed to accompany the Readiness assessment spreadsheet in order to assist facilities to self-assess their readiness to offer a COS-C. Assessment against the standards should be conducted on establishment of the unit and annually following establishment to ensure quality and safe service provision. The assessment process should involve:

- clinicians including nursing, medical and allied health
- hospital executive and administrators
- safety and quality representatives
- consumers.

Overview of the assessment spreadsheet

Domains

Each domain is represented by a tab with the assessment spreadsheet. The assessment process is broken into five domains including:

- Interprofessional collaboration
- Clinical capability
- Policies, procedures and standards
- Safety and quality
- Child and family-centred care

Standard

Within each domain is a set of standards (columns A and B) that are self-assessed by the site. Where standards are similar, they are grouped together by a subheading, such as *2.1 Monitoring* within *Domain 2: Clinical capability*. Within this grouping there are 4 standards listed a to d.

Assessment

For each standard, sites should self-assess using a drop-down list (column C) whether they fully meet, partially meet of fail to meet that standard. There is an option for not applicable in the rare occasion that this is the most appropriate response.

Evidence

For each standard, sites should provide a brief summary of evidence (column D) to back up their self-assessed response. Examples of evidence are listed in the tables below. Note that these examples are not prescriptive and are listed to provide sites with an example of what an evidence statement may contain.

Action needed for improvement

Where a site does not fully meet the standard, site should consider and document the actions needed for improvement (column E). This section can also be used where sites to meet the standard but are seeking further improvement.

Lead

Where actions for improvement have been identified, the identified lead can be documented in column F. The lead may be an individual or group of clinicians, consumers or hospital administrators. Where there are no actions for improvement identified, this section may be left blank.

Timeframe

Where actions for improvement have been identified, the timeframe for the proposed action can be

documented in column G. Where there are no actions for improvement identified, this section may be left blank.

Alignment with the NSQHS

Where a standard relates specifically to one of the National Safety and Quality Health Service Standards (NSQHS), this will be identified. This may assist in documentation during accreditation.

Domain 1: Interprofessional collaboration

Interprofessional practice (also referred to as collaborative practice) occurs in health-care when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings (World Health Organisation, 2010). Interprofessional collaboration supports front-line staff to deliver patient and family-centred care by empowering clinicians and improving communication to ensure a shared understanding of all perspectives. This assists in the delivery of individualised, high-quality care.

Domain subheading	Standard	Examples of evidence *(not intended to be prescriptive)*
1.1 Role clarification	a. Processes to ensure clinicians and support staff understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and meet child and family and community goals.	Examples of evidence: • All clinical and support staff have documented Role descriptions as part of their employment details. • All clinical and support staff introduce themselves and their role to the child and their family. • All clinical and support staff wear identification that shows their role.
1.2 Collaborative leadership	a. Clinicians work together with all stakeholders, including children and families to develop, implement and evaluate care / services to enhance outcomes.	Examples of evidence: • The unit holds multidisciplinary ward rounds to ensure all clinicians work collaboratively to plan, implement and evaluate care. • Cases are discussed as a multidisciplinary group as part of a regular morbidity and mortality meeting.
1.3 Team functioning	a. Education / training to ensure clinicians understand the principles of team dynamics and group processes to enable effective interprofessional team collaboration.	Examples of evidence: • The staff education program for the unit is interdisciplinary and includes simulations involving different disciplines.

1.4 Interprofessional conflict resolution	a. Education / training to ensure clinicians actively engage self and others, including the child and family where appropriate, in dealing effectively with interprofessional conflict.	Examples of evidence: • Staff education for the unit includes communication programs e.g. Speaking Up for Safety. • Staff education includes the use of communication tools such as PACE.

Domain 2: Clinical capability

This domain outlines standards that relate specifically to the provision of clinical services for children that require care at a level that falls between a general paediatric ward and an intensive care unit.

Domain subheading	Standard	Examples of evidence *(not intended to be prescriptive)*
2.1 Monitoring	a. Demonstrated process to encourage parents/carers to participate in clinical assessment and monitoring to ensure clinicians understand what is normal for their child. Notes: Parents/carers may offer a unique perspective regarding subtle changes in their child that may signify a change in clinical status. Parents/carers, particularly those of chronically unwell children, may be able to provide a baseline of what is usual for their child.	Examples of evidence: • Admission form containing information on the child's baseline. • Family encouraged to advocate for child if they are deteriorating to nurse, medical team or through social work. If needs not met family encouraged to use Ryan's rule.
	b. Demonstrated clinician capability in the application and interpretation of haemodynamic and respiratory monitoring.	Examples of evidence: • Assessments of staff inclusive of clinical data interpretation e.g. Transition program Clinical Performance Assessment Tool (CPAT). • Nursing staff undertake relevant courses/training offered on a monthly basis (eg OPTIMUS Bonus simulation training).
	c. Adequate supply of readily available appropriate monitoring equipment for paediatrics.	Examples of evidence: • Standardised close observation bed set-up with equipment available including continuous cardiac monitoring, CO_2 transcutaneous monitor and iSTAT machine (for unit use).

		• Equipment and consumables available to support monitoring devices used within the unit.
	d. Process ensuring that children admitted to the close observation service are reviewed by a medical officer at least every 4 hours and reviewed by a consultant experienced in paediatrics at least 2 times each day.	• Unit policy states the admitted patients required four hourly medical review with 12 hourly consultant review.
2.2 Recognition of the deteriorating child	a. Demonstrated use of Children's Early Warning Tool (CEWT) for all children admitted to the close observation service, including: • charting of observations on the CEWT chart • ensuring scoring is completed and corresponding actions are adhered to.	Examples of evidence: • Observations for children are charted on CEWT score chart. • CEWT scores are completed and corresponding actions are adhered to. • Regular, documented audit of CEWT compliance.
	b. Demonstrated process to encourage involvement of parents/carers in recognition of the deteriorating child.	Examples of evidence: • Parent information booklet including permission for parents to notify staff of concerns. • Facilitate one parent/carer to stay on ward with child during admission process. • Encourage parents to be involved in ward round, decision making and invited to provide written feedback (compliments or complaints). • Ryan's rule handout given on admission.
2.3 Response to the deteriorating child	a. Clear escalation and de-escalation pathways including timely transfer to higher level services in the event the child's condition deteriorates.	Examples of evidence: • Documented escalation and de-escalation policies/guidelines/work instructions easily accessible to all staff. • All children seen at regular intervals by local medical team with escalation to RSQ (tertiary PICU) or local ICU if clinically deteriorates. • Use of TEMSU/telehealth available for clinical decision making and

		transfer.
2.4 Resuscitation	a. Process for regular checking (at least daily) of paediatric emergency equipment (including documentation of checks).	Examples of evidence: • Regular, documented audit of checking of paediatric emergency equipment. • Policy/guideline/work instruction guiding staff on how and when to complete checks of resuscitation equipment.
	b. Readily accessible paediatric resuscitation equipment in close proximity to the close observation service	Examples of evidence: • Regular, documented site audits of paediatric resuscitation equipment proximity to the unit. • Policy/guideline/work instruction for staff regarding placement of paediatric resuscitation equipment. • Paediatric resuscitation equipment signage and labelling, with placement visible from beds within the unit.
	c. Process to ensure medical and nursing staff working in the close observation service have received Paediatric Advanced Life Support training in line with ANZCOR Section 12, Guidelines 12.1 to 12.7.	Examples of evidence: • Policy/guideline/work instruction relating to staff training stating that all clinicians working in the unit must attend and pass (where course is assessed) Paediatric Advanced Life Support training within 12 months of commencement of work. • Records kept of staff attendance at acute paediatric resuscitation training. • Audit of paediatric resuscitations as to whether staff involved had received appropriate training.
2.5 Adverse events	a. Staff have access to debriefing and counselling services to provide support following an adverse event or unexpected death of a child in the close observation service.	Examples of evidence: • For significant patient events including resuscitation or death there is a planned debrief. • Staff have access to confidential external counselling services, such as the Employee Assistance Service.

2.6 Support services	a. Support services (as outlined in the CSCF Table 4) are equipped and trained to meet the need of the COS-C. Notes: The listed support services (eg medical imaging, pathology) may need to initiate additional services or training to ensure that the COS-C can be supported to offer services within the documented COS-C scope.	Examples of evidence: • Discussion held with support services to ensure they are able to provide the support services required to offer COS-C. Additional training and/or equipment arranged.
2.7 Education and training	a. **Skill development**: Processes for the provision of education and training for clinicians to develop skills needed to provide care for children that is intermediate between a general ward and an intensive care setting, appropriate to the level of the close observation service.* Notes: this standard specifically relates to the initial development of skills for close observation service staff.	Examples of evidence: • Comprehensive education program utilising a multi-modal approach, e.g. simulations, online learning (iLearn), workshops, skills stations, courses (e.g. Optimus Core and Optimus Prime, PaedsBASIC, APLS etc) for new staff. • Close observation service staff participation in monthly ICU and ED teaching sessions on paediatric topics with lecture, skills station and simulations. • Close observation service staff participation in weekly Paediatric unit education sessions with monthly simulations. • Education and training in accordance with pre-determined scope (see also 3.1)
	b. **Skill maintenance:** Processes for the provision of education and training for clinicians to maintain skills needed to provide care for children that is intermediate between a general ward and an intensive care setting, appropriate to the level of the close observation service.* Notes: this standard specifically relates to the ongoing maintenance of skills for close observation service staff.	Examples of evidence: • Comprehensive education program available to all close observation service staff utilising a multi-modal approach, e.g. simulations, online learning (iLearn), workshops, skills stations, courses (e.g. Optimus Core and Optimus Prime, PaedsBASIC, APLS etc). • Close observation service staff participation in monthly ICU and ED teaching sessions on paediatric topics with lecture, skills station and simulations. • Close observation service staff participation in weekly Paediatric unit

		education sessions with monthly simulations. • Education and training in accordance with pre-determined scope (see also 3.1)
	c. Process for education and training for clinicians in the provision of paediatric end of life care. Notes: while provision of planned end of life care is not the anticipated use of a close observation service, it is possible that staff may encounter this situation as part of their role. It is therefore important that staff have access to education and training regarding paediatric end of life care.	Examples of evidence: • Documented, regular audit/review of end of life care. • Staff feedback sought and utilised to inform guideline/policy/work instruction on end of life care. • Documented record of staff attendance at training events focused on paediatric end of life care e.g. workshop, in-service, online modules etc. • Access to QPHON (Queensland Paediatric Haematology Oncology Network) workshop in 2020 which emphasised end of life care. • Paper resources available on ward. • Access to hospital palliative team at all hours via phone or telehealth. .
	d. Maintenance of records regarding clinician training / education to ensure ongoing provision of education in a timely manner.	Examples of evidence: • Database with in-service records, transition program completion and other training completed. • Written sign in sheet for all training sessions provided.
	e. Processes to ensure that the involvement of parents/carers in recognition of the deteriorating child forms part of clinician education. Notes: Including parent/carer stories in the education process for clinicians in recognition of the deteriorating child can increase the likelihood of clinicians appreciating the benefit of parent/carer involvement as part of the identification of a child's deterioration.	Examples of evidence: • Staff training program includes reference to parent/carer recognition of the deteriorating child. • Emphasis on the role of parents/carers in recognition of deterioration during weekly paediatric teaching ward rounds and simulation sessions.

Domain 3: Policies, procedures and standardised care

This domain outlines standards that relate to the provision of standardised, evidence-based care. Each close observation service may have a different scope and purpose depending on the requirements of the facility/HHS and the available expertise and support. Below are three examples of different close observation services:

- A regional facility that does not frequently perform paediatric surgery may establish a close observation service that is primarily for medical patients with clear escalation pathways when a child's severity reaches pre-defined limits.
- A facility that offers a range of paediatric surgical procedures may establish a close observation service primarily for post-surgical patients based on a given list of surgeries performed at the facility.
- A facility that offers specific services for example neurosurgery may offer a specialty specific neurosurgical close observation service. This close observation service may be able to manage complex devices such as external ventricular drains, with the support of a local paediatric critical/intensive care unit and paediatric neurosurgical team.

All close observation services need a clearly defined and documented scope and appropriate use of relevant clinical policies, procedures to provide standardised, evidence-based care. The above examples show close observation services that have a very different scope from each other.

Domain subheading	Standard	Examples of evidence *(not intended to be prescriptive)*
3.1 Scope of the close observation service	a. Documented scope that determines the safe functioning of the close observation service Notes: the purpose of this standard is to ensure the delivery of safe, quality care within a pre-determined scope. Where care requirements are above this scope, escalation to a higher level CSCF facility is required. The close observation service may choose to document this scope: • as a list of medical devices that can be managed and/or unit-based procedures that may be safely undertaken in the unit (eg arterial lines, management of non-ventilated tracheostomies, performing non-invasive ventilation, administering inotrope infusions to a pre-specified maximum dose), or • using a condition-based	Examples of evidence: • Documented list outlining the scope of the unit • Adequate and appropriate equipment available in accordance with pre-determined scope (where the scope relates to devices/unit-based procedures). • Education and training in accordance with pre-determined scope (see also 2.6)

	approach within certain limits with pre-determined clinical markers requiring escalation to a higher-level facility, or • as a combination of these.	
3.2 Admission and discharge criteria	a. Documented admission and discharge criteria developed in consultation with services involved in escalation and escalation of care	Examples of evidence: • Policy outlining the clinical admission and discharge criteria has been developed in consultation with the paediatric ward, emergency department and the intensive care unit that is generally involved in escalation of care.
3.3 Standardised clinical pathways and protocols	a. Utilisation of condition-specific standardised pathways and protocols.	Examples of evidence: • Quarterly, documented audit of compliance with pathways and protocols. • Common condition specific local pathways and protocols have been developed and are available in the unit and on the intranet.
3.4 Support from higher-level services	a. Documented processes to access telehealth support from higher-level service and relevant sub-specialties.	Examples of evidence: • Policy or work instruction on the use of telehealth support. • Documentation/tracking of telehealth support sought. • Access to TEMSU in paediatrics with frequent teaching and simulation training.

Domain 4: Safety and quality

Patient safety and quality is often summarised as the right care, in the right place, at the right time and cost. The Australian Commission on Safety and Quality in Healthcare defines patient safety as prevention of error and adverse effects associated with health care; and quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'.

Domain subheading	Standard	Examples of evidence *(not intended to be prescriptive)*
4.1 Patient safety and quality incidents	a. Assess: Recognition of clinical incidents, near misses and active identification of latent safety threats.	Examples of evidence: • Monthly audit of Riskman entries and near misses / latent safety threats. • Daily multidisciplinary ward rounds that seek to identify and reduce potential risk of incidents (where these can be identified) • Discussion of risk assessment, including near misses and latent safety threats at monthly multidisciplinary meetings
	b. Report: Process for reporting of clinical incidents (eg RISKMAN).	Examples of evidence: • Incidents and near misses are reported through Riskman. • Audits are conducted on usage of Riskman to ensure actual usage meets anticipated usage.
	c. Analyse: Process for multidisciplinary analysis of clinical incidents.	Examples of evidence: • Riskman entries are reviewed monthly by a multidisciplinary team as part of monthly morbidity and mortality meetings.
	d. Improve: Quality improvement as a result of clinical incident management.	Examples of evidence: • Outcomes or Riskman analyses through monthly morbidity and mortality meetings are utilised to inform changes to local policy and safety standards.
	e. Communicate: Process for communication and dissemination of information and system changes.	Examples of evidence: • Outcomes or Riskman analyses and any subsequent changes to local policy and safety standards are communicated to staff through email, newsletters and other mechanisms

		suitable to the magnitude of the change.
4.2 Medication safety for paediatric patients	a. Utilisation of dose error reduction software for infusion pumps.	Examples of evidence: • All infusion pumps have dose error reduction software uploaded. • Regular planned and documented audit of dose error reduction software compliance.
	b. Utilisation of standard concentration medication infusion.	Examples of evidence: • Regular planned and documented audit of compliance with standardised IV medications. • Use of Metavision or ieMR for prescribing infusions that provide standard concentration medication infusion. • CREDD book and Paediatric Injectable Drugs Guideline available and encouraged to be used in paediatric unit which standardises the doses and drawing up and administration of intravenous medications.
	c. Access to standard concentration medication infusion resource/s for medication management, prescribing and administration.	Examples of evidence: • Online resource on desktop for medication prescribing and administration on each bedside computer. • CREDD book and Paediatric Injectable Drugs Guideline available and encouraged to be used in paediatric unit which standardises the doses and drawing up and administration of intravenous medications. • Access via the intranet to other statewide resources on medication management.

	d. Specific processes for managing high risk medications, eg vasoactive medications, neuromuscular blockers, etc.	Examples of evidence: • Local guideline/work instruction for managing high risk medications • CREDD book and Paediatric Injectable Drugs Guideline available and encouraged to be used in paediatric unit which standardises the doses and drawing up and administration of intravenous medications. • Access via the intranet to other statewide resources on medication management.
	e. Utilisation of standardised antimicrobial guidelines suitable to the local context.	Examples of evidence: • Regular planned and documented audit of AMS guideline compliance. • Utilisation of the CHQ Antimicrobial stewardship program available on the intranet. • Involvement of the unit in the emergency and inpatient Statewide Paediatric Sepsis Pathway.
4.3 Governance processes to ensure unit is operating safely and effectively	a. Access to training and support in quality improvement methodology.	Examples of evidence: • Access to the HHS Improvement Support Service eg Research Support Unit, Safety Quality Innovation Unit. • All junior doctors encouraged to do a quality improvement activity as part of their training.
	b. Executive level endorsement and support for provision of close observation care for paediatrics.	Examples of evidence: • Documented agreement and support for staffing and resourcing. • Director of Paediatrics and Nursing supported endorsement with collaboration with Hospital Executives.

	c. Defined pathway for escalating governance concerns to executive level.	Examples of evidence: • Pathway documented and easily available for clinicians. • Concerns raised to Director of Paediatrics and other directors involved in care. Further discussions to then be escalated to General Manager and Deputy Director.

Domain 5: Child and family centred care

Children's Health Queensland (CHQ) defines family centred care as 'an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families'. Four core concepts underpinning family centred care as being: respect and dignity, information sharing, participation and collaboration.

Domain subheading	Standard	Examples of evidence *(not intended to be prescriptive)*
5.1 Cultural capability	a. All close observation service staff have completed training or been provided education in cultural capability (e.g. the Queensland Health Aboriginal and Torres Strait Island Cultural Practice Program).	Examples of evidence: • Regular planned and documented audit of cultural capability training compliance • All paediatric staff encouraged to complete cultural competency training available through RACP and Queensland Health.
	b. Clinicians listen to and respect patient and carer values, preferences, beliefs and cultural background.	Examples of evidence: • Parent satisfaction surveys distributed, collected, reviewed, and feedback addressed through documented process. • All nursing and medical staff encouraged to listen to and respect family preferences.

5.2 Vulnerable populations	a. Vulnerable children and families are provided with additional support and referred to appropriate services as required, including crisis support or community support.	Examples of evidence: • Documented referral for additional support as required (medical records) • Child and family social worker available during business hours and access to hospital social worker after hours during day if required. • Further social work support available from CHQ through telehealth if required out of hours for crisis support.
5.3 Partnering with families	a. The family is acknowledged as expert in the care of their child, and the perspectives and information provided by the family contribute to clinical decision-making.	Examples of evidence: • Parent information booklet including permission for parents to notify staff of concerns. • Facilitate one parent/carer to stay on ward with child during admission process. • Encourage parents to be involved in ward round, decision making and invited to provide written feedback (compliments or complaints). • Ryan's rule handout given on admission. • All nursing and medical staff encouraged to listen to and respect family preferences with regards to clinical decision-making.
	b. Close observation service staff empower children and families to participate in shared decision making.	Examples of evidence: • Encourage parents to be involved in ward round, decision making and invited to provide written feedback (compliments or complaints). • All nursing and medical staff encouraged to listen to and respect family preferences with regards to clinical decision-making.
	c. Facilities are available and a family member is encouraged to stay with the child at all times while the child is admitted to the close observation service.	Examples of evidence: • Recliner chairs at each bed space. • All rooms have facilities for an accompanying adult to stay overnight.

5.4 Adverse events	a. Families that experience an adverse event or unexpected death of a child in the close observation service are referred to support services as appropriate (e.g. social worker or bereavement counsellor).	Examples of evidence: • Statewide Paediatric Palliative care services available through telehealth if required. • QPHON (Queensland Paediatric Haematology Oncology Network) education day 2020 emphasized end of life care. Paper resources available on ward.
5.5 Formal consumer engagement in design and quality improvement processes	a. There are formal processes for ongoing evaluation of care from a child and family perspective. This should include feedback from the child (where age appropriate) and family members, through interviews, surveys and/or focus groups.	Examples of evidence: • Regular planned and documented audit of Discharge questionnaires. • All patient admissions offered access to formal compliments and complaint. • Close observation questionnaire will be available and reviewed as a quality assurance activity.
	b. Children and families are included in the development and evaluation of family resources, clinician training and facility design.	Examples of evidence: • A consumer representative group is documented, available and members are invited to numerous opportunities. • Feedback obtained through complements and complaints and Discharge (or other) questionnaires are used to plan training and facility design/change. • All resources developed for consumers have been reviewed by a consumer prior or drafted in collaboration with consumer/s.

Further reading

Domain 1: Interprofessional collaboration

- Queensland Health Interprofessional practice webpage https://www.health.qld.gov.au/cunninghamcentre/activities/074
- CHQ interprofessional practice webpage https://qheps.health.qld.gov.au/childrenshealth/html/education/interprofessional-practice
- Canadian Interprofessional Health Collaborative: A National Interprofessional Competency Framework. February 2021 https://drive.google.com/file/d/1Des_mznc7Rr8stsEhHxl8XMjgiYWzRIn/view
- World Health Organization: Framework for action on interprofessional education and collaborative practice https://www.who.int/hrh/resources/framework_action/en/

Domain 2: Clinical capability

- Australian Resuscitation Council – Australian and New Zealand Committee on Resuscitation (ANZCOR) Guidelines https://resus.org.au/guidelines/anzcor-guidelines/
- Clinical Excellence Queensland: Care plan for the dying child https://clinicalexcellence.qld.gov.au/resources/clinical-pathways/care-plan-dying-child

Domain 3: Policies, procedures and standardised care

- Queensland Health: Clinical guidelines and procedures https://www.health.qld.gov.au/clinical-practice/guidelines-procedures
- Children's Health Queensland Governance eCatalogue https://qheps.health.qld.gov.au/childrenshealth/resources/html/alpha-list (Please use local policies, procedures and guidelines where these are available)

Domain 4: Safety and quality

- Australian Commission on Safety and Quality in Healthcare (including National Safety and Quality Health Service Standards) https://www.safetyandquality.gov.au/.
- Queensland Health – Patient Safety and Quality Improvement Service homepage https://qheps.health.qld.gov.au/psu
- Queensland Health – Patient Safety and Quality Improvement Service – Clinical Incident Management https://qheps.health.qld.gov.au/psu/clinicalincident.
- Queensland Health – Patient Safety and Quality Improvement Service – Accreditation https://qheps.health.qld.gov.au/psu/safetyandquality/accreditation-qh.

Domain 5: Child and family centred care

- Queensland Child and Youth Clinical Network – Family-centred care resources https://www.childrens.health.qld.gov.au/chq/health-professionals/qcyc-network/resources/.
- Children's Health Queensland – Family-centred care https://qheps.health.qld.gov.au/childrenshealth/html/about-us-fcc.

General resources

- Queensland Child and Youth Clinical Network https://www.childrens.health.qld.gov.au/chq/health-professionals/qcyc-network/.