Professional standards for anaesthesia in children
Standards / visitation system

The standards for anaesthesia in children are expressed as a minimum standard and two target standards. The standards system is structured according to a three-point scale (see box 3-5).
The visitation assessment instrument is directly linked to the standards and adds two underlying levels, which can be used to indicate the extent to which a department does not meet the standards. Recommendations and advice from the audits will be directly linked to these lower two levels (see Box 1-2).

1 Substandard
2. Substandard
3. Minimum standard - The insight, the measure or the intervention has been implemented and one works according to agreement
4. Good practice - Implementation and results are evaluated and lead to reflection and improvement
5. Best practice - In this area, the department actively contributes to innovation within and/or outside the hospital.

Below, the professional standards set is presented.

Regular and/or plannable care*

3. Written agreements have been made about which interventions on children within your hospital are regular and/or plannable care (including agreements about activities during and outside office hours) based on the flow chart in the guideline.
4. The written agreements for regular and/or plannable care for children (during and outside office hours) are implemented throughout the entire integrated care process.
5. The department regularly checks whether the agreements on regular and/or plannable care for children are sufficiently embedded in the chain care process and if necessary takes the initiative to adjust the integrated care process.

Acute care

3. Agreements have been made with which it is immediately clear who (anaesthetist, surgeon, paediatrician, etc.) is responsible when and for which part(s) of a child's acute care. The agreements cover 24/24 hours and 7/7 days a week, with accessibility and availability being arranged.
4. Written agreements have been made with an adjoining and/or reference hospital.
5. The department regularly evaluates the internal and external agreements and adjusts them if necessary.

Dutch Association of Anaesthesiologists (NVA, *Nederlandse Vereniging voor Anesthesiologie*)
Professional standard: Professional development - Compliance with NVA volume standards

3. The department meets the current volume standard(s) set by the NVA.
4. The department complies with the current volume standard(s) set by the NVA. The department evaluates annually whether it will also meet these standards in the coming year and if necessary adjusts its organization/policy on the basis of the evaluation.
5. The internal evaluation and adjustment are also discussed regionally. As a result, agreements on regional volume distribution have been made/adjusted.

Include the two questions below in the questionnaire for the individual anaesthetist:

1. Do you give anaesthesia to children within the regular and/or plannable care* of your hospital? Yes/No
2. If so, how many times a year do you give anaesthesia to children? [Number] within the regular and/or plannable care*? * refers to the number of anaesthesia's given.

The following will be included in a volume standards document
Four risk groups are discerned in the anaesthesiological care for children (see box and guideline where applicable). An anaesthetist who gives anaesthesia to children does this at least 10 times a year within regular and/or plannable care* and within one age risk group. If an anaesthetist has given anaesthesia 10 times within the youngest age risk group, this number does not have to be achieved again for the risk groups at older age.

Group 1: Term-born infants until 4 wks. of age + prematurely born infants < 60 wks. postconceptional age Group 2: Term-born infants > 4 wks. of age + prematurely born infants > 60 wks. postconceptional age Group 3: 1- and 2-year-olds Group 4: 3 years and older

Competence levels1
3. The department works according to the division of the three competence levels.
4. The department works according to the division of the three competence levels, whereby the department provides further training / courses to fulfil this.
5. Working according to the division of the three competence levels is demonstrably evaluated and, if necessary, adjusted.

[1] The three competence levels are: paediatric anaesthetist; anaesthetist with a focus on paediatric anaesthesia; and general anaesthetist. For more information about the competence levels, please refer to the guideline.

Recovery room team
3. The department verifies that the recovery room team has been trained for child care – according to the requirements of their own professional association – and participates annually in PBLS training.
4. In its own hospital, the department is involved in the training, retraining and refresher courses of recovery room personnel for child care.
5. The department contributes regionally/nationally to the training and further education of recovery-room personnel for child care.

Transfer (transfer of responsibilities; recovery unit)

3. A verbal transfer in a structured format takes place at the time of transfer from the recovery unit to the ward. This is recorded in the patient file. A standardized recovery discharge score – with standards and criteria for discharge – adapted for children is used.
4. The minimum standard is met. The recovery discharge scores are also regularly evaluated within the department and the care process is adjusted if necessary on the basis of this.
5. The previous target standard will be achieved. The recovery discharge scores shall also be regularly evaluated in a multidisciplinary manner and, if necessary, the care process shall be adjusted accordingly.

Pain scores registration

3. The department records age-specific pain scores postoperatively in the recovery room and subsequently on the nursing ward. The department systematically discusses the results. A child pain protocol is used.
4. The department records age-specific pain scores postoperatively in the recovery room and subsequently on the nursing ward. The department systematically discusses the results and adjusts the child pain protocol on the basis thereof.
5. The department records age-specific pain scores postoperatively in the recovery room and subsequently on the nursing ward. The department systematically discusses the results in a multidisciplinary context and adjusts the organization-wide child pain protocol on the basis thereof.

Protocols

3. The guideline “Anaesthesia in children” and the applicable protocols of the NVA paediatric anaesthesiology section have been translated into local protocols and work instructions for child anaesthesia care, and these have been implemented in the daily process.
4. The implemented local protocols and work instructions for paediatric anaesthesia care – based on the guideline “Anaesthesia in children” and the protocols of the NVA paediatric anaesthesiology section – have been brought in line with protocols of other medical departments. In addition, each new protocol is assessed for its consequences for paediatric anaesthesia care.
5. The implemented local protocols and work instructions for paediatric anaesthesia care – based on the guideline “Anaesthesia in children” and the protocols of the NVA paediatric anaesthesiology section – are structurally evaluated within the department and with other specialties. They are updated on this basis. In addition, each new protocol is assessed for its consequences for paediatric anaesthesia care.

Perioperative care of neonates

Only applicable if anaesthesia care is provided in the hospital to term-born infants up to the age of 1 month and/or premature children up to a postconceptional age of 60 weeks.

3. The perioperative care of these high-risk patients is – possibly with locally clearly defined adjustments – based on the recommendations "perioperative care for neonates".
4. The standard is met. There is also a regular meeting attended by neonatologists, anaesthetists and paediatric surgeons where case studies, complications, protocols and policy of this group of high-risk patients are discussed.
5. The previous target standard is met. A delegation from the department also actively participates in the national discussions of the perioperative neonatal encephalopathy’ task force and the development of the ’perioperative care for neonates’ guideline with recommendations

*[3] * Definitions: Plannable care = elective care. Regular care = both elective care and non-elective care that takes place so frequently in a hospital that this care may be grouped under the denominator of regular care of the hospital concerned. Think of appendectomy in the acute phase of appendicitis; this type of intervention is not plannable and often regular care.*