Guideline setting out the operational principles covering the admission and on-going care of paediatric patients to adult critical care beds at St George's

Document reference

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Introduction and definitions

In response to the updated NHS England PICU surge SOP (November 2018), other recent operational pressures and reviews [*see references*], we have been asked to formalise the existing informal arrangements between paediatric and adult critical care services at St George's.

There are chronic (episodic) capacity issues in both paediatric, and to a lesser extent adult, ICU provision at St George's. These are due both to limited physical bed spaces and chronic staff shortages. To add to the pressures on PICU, there are also regional and national capacity issues.

Historically, the adult critical care service at St George's has provided assistance to PICU in times of need in 2 ways, deploying adult ICU nursing staff to PICU and admitting paediatric patients onto one of the adult ICUs.

The aim of this document is to provide practical guidance (not a rigid protocol) for managing short-term (hours to days), exceptional, surge capacity requirements for paediatric intensive care. The intention is not to create an operational framework to increase the provision of paediatric critical care at St George's.

For the purposes of this document a paediatric patient is defined as anyone under 18 years of age and / or in full-time secondary education.

Foreseeable circumstances when admitting paediatric patients to adult ICU beds may be considered

- Winter surge demand for PICU beds due to seasonal respiratory tract infections
- Multi-person trauma incidents involving paediatric patients
- Adolescent patients who request care in an adult environment (it is widely recognised that some adolescent patients are suboptimally served by both paediatric and adult services)
- Adolescent patients whose pathophysiology is more adult than paediatric in nature e.g. a 17 year old with multiple stab wounds
- Adolescent patients who require emergency OR urgent surgery. [Definitions: *emergency* = life, organ or limb at immediate risk unless operated on; *urgent* = where a delay in surgery is likely to result in an immediate significant negative physiological impact on the patient]

Triage principles for admitting a paediatric patient into an adult ICU bed

None of these principles are absolute nor are they listed in a hierarchical order.

- Age (size): older (and larger) patients are more suitable than younger (smaller) patients.
- Complexity: patients with acute, simple, single system, common pathology are more suitable than patients with complex / chronic , multi- system, paediatric (specialist) pathology
- Severity: lower severity is preferable to higher severity
- Stability: greater (anticipated) stability is preferable to less stable patients
- Acute admissions verses transfer of chronic patients: an acute admission, expected to recover rapidly is preferable to transferring a patient who has been on PICU for an extended period

Lines of communication medical, nursing and AHP

- All requests should be initiated as consultant to consultant referrals
- Nursing shift leaders for both services should consider and agree on whether the adult ICU in question can safely provide care or whether a PICU nurse and an adult ICU nurse should swap over to facilitate the admission. This may vary shift by shift and as far as possible be planned in advance.
- Similar considerations may need to made for relevant AHPs
- Which teams are responsible for what elements of care should be agreed and clearly documented in the patient's record in Cerner (iCLIP).
- Emergency contact information for clinical colleagues should be clearly established

Managing patient and family expectations

- Admitting paediatric patients into adult beds is suboptimal (lack of familiarity and expertise), represents a compromise and should only occur in exceptional circumstances. However, it may be the optimal pragmatic solution in specific circumstances.
- Adult ICU environments are less child and family friendly in their design and general environment. Patients / their families should be counselled as to what to expect.
- Facilitating a parent / carer staying with the patient 24/7 should be accommodated
- If possible, paediatric patients should be admitted to side rooms on adult units.

Mutual aid principles including scheduled in-reach, ad hoc advice, staff swaps and crisis management

- Paediatric patients in adult ICU beds should have scheduled reviews twice daily by the PICU Consultant or representative *UNTIL* it has been mutually agreed that the patient only has adolescent / adult pathophysiological problems *AND* can reasonably considered to be an older adolescent / young adult
- There should be clear arrangements for as required (non-urgent) paediatric advice
- There must be a clearly documented plan, including the provision of any special equipment, for any foreseeable emergency (which has a significant probability of occurring).

References

1. *Letter from* Dr Michael Marsh, Medical Director NHSE Specialised Commissioning, London Region; dated 15th November 2018; "Re: Paediatric Intensive Care Winter Surge"; *available at* L:\Files\Critical Care Directorate\!GICU - General ICU Care Group\GICU - Governance meetings\2018\2018 11(nov)
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