High Dependency Care of Children Guideline

Women and Children's Directorate

Guideline Number:	917	Supersedes:		Classification	Clinical
LOCSSIP Reference:		NATSSIP Standard:	List standard (NATSSIPS Standards)		

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
1	07/2020	Paediatric Clinical Written Control Documentation Group	31/07/2020	04/08/2020	31/07/2020

Brief Summary of Document:	This guideline outlines best practice on specific indications for admissions for HDC within Hywel Dda University Health Board. This guidance offers definitions of HDC and provides guidance on admissions, nurse staffing and transfers between units, and is based on All Wales Standards Critical care guidance , HDC for children – Time to Move on document from the Royal College of Paediatric and Child Health.
Scope	The statements included in the guidance apply to the 4 acute hospitals within Hywel Dda including paediatric, emergency departments, Anaesthetics who are involved in making decision regarding a Child who requires HDC This guidance applies to all referring practitioners and HDUHB staff who are providing clinical care to children who may require HDC , A child who is not critically ill may be classified as requiring HDC based solely on the requirement for additional nursing resources. The scope of an acute stabilisation of a child who requires transfer to Paediatric intensive care Unit (PICU) the well-established guidance for those situations already exist (PICS Standards 2010, Tanner Report 2006 , Advanced Paediatric Life Support (APLS) with a focus of collaborative working between anaesthetist , emergency departments and the paediatric team for care of critically unwell child and require acute stabilisation and retrieval .

To be read in conjunction with:	692 – Admission of children to paediatric units policy 514 – management and investigation of incident policy 489 – emergency pressure and escalation policy 354- standards infection prevention and control precautions policy All Wales Critical care standards PICS Quality Standards for the Care of critically ill children (5th Edition 2015) All Wales safeguarding procedures 2019 HDC for children Time to move on RCPCH 2014
Patient Information:	

Owning committee/ group	Janet Millward Senior Nurse Manager paediatric Prem Pitchaikani clinical Lead paediatrics Women and Children written control documentation Group

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	31/07/2020

Glossary of terms:

Term	Definition
APLS	Advanced Paediatric Life Support
EPLS	European Paediatric Life Support
PHDU	Paediatric High Dependency Unit
PICU	Paediatric Intensive Care Unit
PILS	Paediatric Immediate Life Support
HDC	High Dependency Care

Keywords	Paediatric High dependency Children

Contents

1. Scope

Hywel Dda University Health Board incorporates four hospitals. For Acute Secondary Paediatric High Dependency Care(HDC) there is a Paediatric HDC Unit in Glangwili Hospital and a Paediatric High dependency stabilisation area within the paediatric inpatient unit on Angharad ward in Bronglais Hospital. There is a stabilisation area with the Paediatric Ambulatory Care unit in Withybush Hospital.

HDC is described as a requirement for close observation, monitoring or intention that cannot be delivered in a normal ward environment, But as the same time does not require admission to an intensive care unit.

The guidelines for the acute stabilisation of the critically Ill child who requires urgent admission / transfer to Paediatric Intensive Care unit is detailed in the Paediatric Intensive care Standards (PICS) and that defines the role of emergency department , anaesthesia and paediatric .

The PICS Standards expectation is that any hospital delivering in – patient paediatric care should be able to look after a child requiring HDC (HDC) as well as initiate acute stabilisation for a child requiring transfer to PICU.

PHDU provides level 1 care and for those needing initiation of level 2 intensive care and stabilisation pending transfer to the Paediatric Intensive Care Unit .

2. Aim

The guideline outlines best practice for children requiring Paediatric High Dependency Care. Children who are admitted for HDC require High Dependency Nursing and medical care which provides close observation, monitoring and therapies to children who are, or have significant potential to be Physiologically unstable and whose care requires increase nursing input compared to a general paediatric bed establishment.

This guideline provides specific information on the admission criteria, ensure appropriate and timely admission of children to PHDU and facilitate utilisation of limited capacity and staffing resource .

3. Objectives

The aim of the guidance will be achieved by :

- Ensuring that all HDUHB staff utilise the standards and criteria outlined in this document
- Ensure that children receiving HDC are care for in the appropriate area providing nursing, medical and therapy care as recommended by the paediatric intensive care society guidance for the care of the critically ill and injured children within a general hospital (PICS)
- The staff of HDUHB should be clear about their role in the care of critically ill children and the role of other departments that may be expected to provide elements of this care.
- To provide defined standards of care for children and young people requiring HDC
- To provide a multidisciplinary approach to paediatric high dependency care
- To provide a framework that allows auditing and monitoring of paediatric high dependency care
- To ensure that all services comply with published guidance on health services for children and young people, in particular National Service Framework for children and specialised standards

- To ensure that all children's areas within HDUHB caring for critically ill children has staff with the necessary competencies and that these competencies are appropriately maintained.

4. Guideline

4.1 INTRODUCTION

The paediatric team provides a range of general and specialised care to Children. At each of the three sites in Hywel Dda University Health Board, children's facilities provide care for all specialities and ages and include Paediatric Ambulatory Care Units. All three sites have emergency departments with a major resuscitation area that includes a designated paediatric section.

The Paediatric HDC Unit (PHDU) provides close observation, monitoring and therapies to children, who are, or have a significant potential to be, physiologically unstable and whose care requires increased nursing input compared to a general paediatric bed establishment.

Admission for HDC is governed by the degree of physiological instability as much as diagnosis

Children are then transferred from PHDU when either their physiological condition stabilises to the point where they can be cared for on a general ward, or their condition deteriorates and they require care on a Paediatric Intensive Care Unit (PICU).

Children who require HDC nursing and medical may Day case scheduled admission and this may include post-operative management.

Children who require specialist cardiac, neurological, renal or hepatic care are referred to appropriate specialist centres as per the All Wales Specialised Standards.

HDC is also required by those needing initiation of Level 2 intensive care and stabilisation pending transfer to the Paediatric Intensive Care Unit (PICU). For many of these children the need for intensive care is apparent on admission to hospital but some develop this need as their illness progresses following admission to hospital.

The Paediatric Intensive Care Unit for Wales is located in the University Hospital of Wales, Cardiff. A range of paediatric specialities including nephrology, neurology, oncology and some specialist surgical care including neurosurgery is provided. The Welsh Centre for Burns and Plastic Surgery is located in Morriston Hospital, Swansea.

HDC provides child and family-centred care and partnership in care for children, with parents/carers and families as per the National Service Framework.

HDC aims to provide nursing, medical and therapy care as recommended by the Paediatric Intensive Care Society (PICS) guidelines for care of critically ill and injured children within a General Hospital (PICS, 2015)

HDC services are available to all critically ill children from the point of discharge from maternity or a neonatal unit aged up to 16 years (15 and 364 days).

To provide high quality paediatric HDC within our Children's Service which meets the standards set out in National Guidance for -

- Critically ill children whose severity of illness does not require acute invasive ventilation or specialist care.
- The care of long term ventilated children, either while waiting for discharge to the community or during treatment of episodes of inter current illness.

For Paediatric HDC in a DGH the following services must be co-located (i.e. available 24/7 on the same hospital site).

- General paediatrics
- Anaesthetics
- ENT surgery

4.2 AGE DEFINITIONS FOR ACCESS TO HDC BEDS

- Child and young person – 0-16 years – automatic admission
- Age 16-17 and 364 days should be discussed with adult intensivists
- In special circumstances, e.g. young person with special needs and under the care of a paediatrician, admission beyond the 18th birthday may be arranged

On occasions, it may be appropriate for young people beyond their 18th Birthday to remain within paediatric services, either because the underlying disease process is predominantly paediatric or because of their stage of physical or emotional development. These young people must be under the care of a local paediatrician within children's services with an agreement for care up to their 19th Birthday.

These guidelines provide support for practitioners' clinical and professional judgement across secondary care in HDUHB when Paediatric HDC is needed.

4.3 ADMISSION CRITERIA FOR THE PAEDIATRIC HIGH DEPENDENCY CARE UNIT

HDC requiring nurse to patient ratio of 1 nurse to 2 patients.
The PICS 2010 Standards identify that in the following situations children may be admitted to PHDU

- Need for single organ support (excluding advanced respiratory support)
- Need for more detailed observation/monitoring than can be safely provided on a general ward.
- Post operative patients who need close monitoring for more than 4 hours.

Aim: To provide care to a Child or Young person who requires closer observation and monitoring than is available on the ward (DOH 2001)

The service will follow the standards and criteria outlined in the general specification for children's specialised services and meet core PICS standards

The lead consultant will be a member of the Paediatric Critical Care Network and audit activity within the PHDCU.

The service will accept referral for children who meet the criteria, subject to capacity. Where demand exceeds capacity a service wide process of prioritisation will be required.

Principles:

- ❖ Any child requiring very frequent observations and monitoring e.g. more than hourly, should be considered for HDC

- 1 nurse caring for a maximum of 2 children at any one time will stay in the HDC area.
- A Consultant must be informed of all admissions for HDC.
- The child or young person should be assessed at least every 2-4 hours by the medical team or more frequently as indicated.
- Transfer or retrieval to PICU or another specialist unit may be necessary and should be assessed on an individual basis, using the PICU Care Bundles and Retrieval Communication Tool.
- Stabilisation of a critically ill child prior to retrieval should occur in the HDC area or an alternative safe designated area e.g. theatre.
- Children no longer requiring HDC will be moved to the general ward as soon as possible.
- A debrief will be arranged for all staff involved in any retrieval /difficult case. This will be organised by the Consultant involved in the care of the child or young person.

Staff Representatives;
In accordance with PICS (2010) recommendations, there will be an identified Specialist Lead Nurse and Lead Consultant for PHDU.

Each will be responsible for policies and procedures related to high dependency care.

Suggested Criteria for admission to PHDU:
The decision to initiate HDC is a joint medical and nursing one, but children likely to need admission include those with:

- Acute severe/life threatening asthma requiring intravenous medications such as salbutamol
- Croup requiring adrenaline nebulisers or with evidence of clinical deterioration
- Compromised/unstable airway requiring assessment by anaesthetist
- Upper airway obstruction where tracheitis or epiglottitis is suspected and critical care necessary
- Acute bronchiolitis and in a high risk group: ex-preterm, congenital heart disease, neuromuscular disease, cystic fibrosis, immunodeficiency, infants requiring 40% oxygen or suffering recurrent apnoeas (= 2 significant apnoeas with colour change)
- Vapotherm or Continuous Positive Airway Pressure (CPAP) support
- Significant head injuries or those with persistent neurological symptoms/signs or a GCS <12, where the GCS does not improve despite medical therapy or intervention. These children require 15 minute neurological observation
- Status epilepticus requiring ongoing treatment, or recurrent seizures
- Diabetic Ketoacidosis
- Circulatory instability due to hypovolaemia requiring intravenous fluid resuscitation >10ml/kg and/or intravenous inotropes
- Post-resuscitation where HDC is considered appropriate
- Febrile neutropenia episodes with :
  a) poor perfusion CRT >4
  b) shock,
  c) toxic state
  d) impending/actual organ failure
- Unstable cardiac arrhythmias requiring ongoing treatment
- Acute renal failure (urine output less than 1ml/kg/hr) with electrolyte, ECG or BP abnormalities
- Meningococcal septicaemia (pre transfer) or stable–state meningococcemia (with haematological or biochemical abnormalities or prior to retrieval to PICU)
- Bacterial meningitis, meningitis of undetermined cause or encephalitis if clinically unstable or reduced GCS

- Following life threatening poisoning including alcohol, requiring intravenous therapy or frequent observations/monitoring.
- Blocked tracheostomy or acute increased oxygen requirement in a child with airway support
- Post-operatively where it is felt to be appropriate as per local agreement
- Admission for infliximab infusion in children as per protocol
- Specialist Anaesthetic support for sedation services to facilitate radiological procedures and interventions (for example MRI) and for assistance with vascular access in babies and children with complex needs such as intravenous feeding.

Exclusions

- Adults
- Infants who have not been discharged from Neonatal Unit
- Children for whom this level of care is deemed to be inappropriate as result of an agreed Advance and Emergency Care Pathway.

A child fulfilling the criteria identified will need admission for HDC . Data should be collected on each child receiving HDC on the data form (Appendix 1) taken from the All Wales Audit of Critically Ill Children (Caring for Critically Ill Children Standards, WAG 2003).

Both nursing and medical staff can make the decision to admit a child to the HDU, but the **PAEDIATRIC ON CALL CONSULTANT MUST BE NOTIFIED OF EVERY ADMISSION.**

All children within the HDU should be seen by the Paediatric on call Consultant as soon as possible after admission and within 12 hours in every case.

Following review by the Paediatric Consultant, consideration should be given to informing the anaesthetic team/intensive care team as appropriate
In an emergency the anaesthetic team should be called prior to or at the same time as the Paediatric Consultant.

For PICU Advice or transfer this should be sought from the WATCH paediatric critical care transport service for Southwest England and South Wales . The WATCH team are responsible for co-ordinating the transfer of all referrals to the PICUs in Bristol and Cardiff as appropriate. Please contact on **0300 0300 789.** (Appendix 2)

All communications and advice on clinical management, stabilisation and transfer where appropriate should be via the Paediatric Consultants and Anaesthetists .It is essential when a referral is made for retrieval that PICU referral form is used (Appendix 2).

Surgical specialities – ENT, General Surgery, Trauma & Orthopaedics
All hospitals providing care for children including those providing surgical care for elective, day case or emergency patients should have arrangements in place for high dependency care. These arrangements should include 24 hour availability of medical staff with the appropriate competency in Advanced Paediatric Life Support (APLS).

Any child requiring surgery who has an existing medical condition or complex needs must be pre-assessed with discussions and plans for PHDU organised pre-operatively if appropriate.

4.4 Service description/Care Pathway

There are two situations where PHDU care may be required –the care of the critically ill child and the care of the child on long term ventilation

Critically ill children may present to any hospital within the HDUHB. At presentation they are assessed and stabilised. Subsequent care and the most suitable area for this care depend on the level of care needs/treatment required following stabilisation. The decision to transfer for HDC will be made by the Consultant Paediatrician and/or Consultant Anaesthetist.

Children may require:

- General ward care provided in the general inpatient ward
- Basic level critical care – HDC
- Advanced level critical care, which is usually provided in a regional PICU but occasionally, may be provided in an Adult ICU.

The High Dependency Care Unit should have a contingency plan in order to expand capacity to meet demand arising in times of peak demand.

There are a number of children living within the area who have been established on non-invasive ventilation. This is initiated by Specialist Units but may require ongoing local PHDU provision. Discharge to home may be a protracted process requiring multiagency involvement, adaptations and provision of a package of care and training. In many areas care continues in the regional unit there is provision for PHDU care in HDUHB so care of these children can be closer to home. This also enables the HDUHB staff and the family to become familiar with each other. The child may then be admitted to their local PHDU for the treatment of some intercurrent illnesses.

Specialist acute pain services for babies and children within PHDU include provision of agreed hospital wide guidance for acute pain, the safe administration of complex analgesia regimes including PCA and input from the acute pain nurse with expertise in children.

4.5 Transfers

There should be a 24 hour service for the transfer of critically ill children to the HDC Unit . This Service should operate without compromising the care of children. All transfers should be carried out by staff with appropriate training and equipment. For further standards on transfer HDUHB discharge and transfer of care policy 370 .

4.6 Discharge criteria

The decision to transfer a child to the ward area for HDC should be made only after discussion with the Paediatric Consultant on-call

5. NURSING STAFF RATIOS

The Nursing requirements for infants, children and young people requiring HDC have been defined in the RCN document Defining Staffing Levels for Children and Young People's Services (2013). While use of the children's HDC assessment tool (Rushforth et al, 2012) can assist the assessment of staffing requirements for high dependency care, the following registered nurse to patient ratio should be applied regardless of the setting:

The child may need two nurses initially until their condition is stabilised. Thereafter the nurse to patient ratio will be governed by the levels of care and patient dependency as recommended by the 2010 PICS guidelines

- 0.5:1 registered nurse: patient for children requiring close supervision and monitoring following surgery, those requiring close observation for mental health problems or with single system problems.
- 1:1 registered nurse: patient, where the child is nursed in a cubicle, has mental health problems requiring closer supervision, or where the condition of the child deteriorates and will require intensive care. This higher ratio will also be required during the admission process until the child is fully admitted and stable.

All nurses working in high dependency settings should have core knowledge, skills and competencies recognised at a local level for educational provision within the HDUHB.
For the Senior Nursing team it is desirable to have training in high dependency nursing. Nurses will be expected to build up a portfolio with evidence of achievement within the KSF dimensions. Clinical competency will be assessed by the individual's workplace mentors following training.

Medical staff training – all medical staff in training should receive appropriate induction on the care of children in PHDU. More senior medical staff (consultants and non training grade doctors) must ensure they remain up to date with EPLS /APLS training and current guidelines and standards from PICS.

Workforce planning should be undertaken to ensure medical and nurse staffing levels are sufficient to meet the requirements of children requiring high dependency care.

Note that PICS (2010) states that the dependency of a level 1 patient increases to level 2 if the child is nursed in a cubicle.

It would be possible for one nurse to care for two children within PHDU if levels of care and patient dependency are 0.5:1

Ultimately it is the responsibility of the nurse in charge to determine staffing requirements depending on dependency levels and in consultation with the consultant on call. The shift co-ordinator will ensure this happens

6. NURSING/MEDICAL/THERAPY STAFF COMPETENCIES

Children should receive a high standard of care at all times within the PHDU, and assessment, measuring and monitoring of vital signs should be carried out in accordance with the guidelines issued by the Royal College of Nursing (2007, Available on HDC Unit)

It is the responsibility of Senior Nursing and Medical staff to ensure Junior Nursing and Medical staff are supported when caring for the critically ill/injured child.

It is the responsibility of the Paediatric Therapy Service Leads to ensure that therapy staff working in HDC has the required competencies.

The Nurse in charge is responsible for appropriate allocation of experienced Nursing staff members to care for the child in HDC Unit.

All new Nursing and Medical staff receives comprehensive orientation to the PHDU on induction.

Individuals are responsible for ensuring that they are able to locate all equipment needed for emergency/HDU use and are familiar with its use. Each staff member should complete the

equipment competency forms and undertake the HDUHB competency training for infusion pumps, cardiac monitors and other specialist equipment as per the training matrix.

All Staff will complete the mandatory PILS and EPLS/ APLS certification as appropriate to their experience as recommended by PICS (2010). Refresher training will be achieved through educational sessions and simulation training.

7. CORE STANDARDS FOR PHDU

Support for children and young people and their families is needed throughout their critical illness. Guidance on facilities and support is detailed in the PICU Standards in relation to play provision, child friendly environment, parental access, visiting and overnight accommodation, parent information and support services e.g. spiritual support, social care, interpreters, bereavement support.

8. MAINTENANCE OF EQUIPMENT AND SUPPLIES

All equipment must be appropriate and readily available for the resuscitation and stabilisation of critically ill children of all ages as per Appendix 3 of the PICU standards 2010. Medication and equipment should be checked in accordance with local policy and with the Paediatric Intensive Care Society standards (2010).

It is the responsibility of the Nurse in Charge to ensure that all equipment is available and ready for use at all times as per minimum equipment and drug list for cardiopulmonary resuscitation in Acute Care Resuscitation Council (UK) 2013

Staff will be responsible for equipment storage checking procedures and cleaning schedules

All staff are responsible for reporting faulty equipment and identifying in a timely manner when essential stocks are running low.

In accordance with PICS (2010) recommendations, there will be an identified lead Nurse and lead Consultant who will be responsible for policies and procedures related to HDC.

9. FAMILY CENTERED CARE

HDC is distressing for the child and their family and all staff have a responsibility to minimise this through good communication. Parents should be provided with the HDUHB information leaflet on high dependency care.

Staff will ensure families are fully informed of their child's plan of care and encouraged to participate in their child's care as appropriate.

Consideration will be given to flexible visiting as appropriate and this may include allowing both parents to stay initially until the child is stabilised. This may be achieved through utilising the spare bed space in HDU if available as there is no available accommodation off the ward.

Staff will ensure that parents are encouraged to rest and that their basic needs are met. They should be shown the parents' room, shower and canteen facilities on admission.

When a child requires transfer to a specialist centre, the parents will be informed and the rationale for the decision explained. They will be provided with a parent information sheet (Appendix 5) regarding HDC and efforts made to ensure their safe transfer to the receiving hospital

10. FURTHER INFORMATION AND REFERENCES

Quality standards for cardiopulmonary resuscitation practice and training; Resuscitation Council (UK) Nov 2013 www.resus.org.uk

Minimum equipment and drug lists for cardiopulmonary resuscitation: Resuscitation council (UK) 2013 www.resus.org.uk

The Paediatric Intensive Care Society Standards for the Care of Critically Ill Children 4th Edition 2010 www.ukpics.org.uk/documents/PICS_standards.pdf

Caring for Critically ill Children Standards WAG (2003) http://www.cardiffpicu.com/pdf/Welsh%20PIC%20standards.pdf

National Service Framework for children http://www.wales.nhs.uk/sites3/documents/441/EnglishNSF_amended_final.pdf

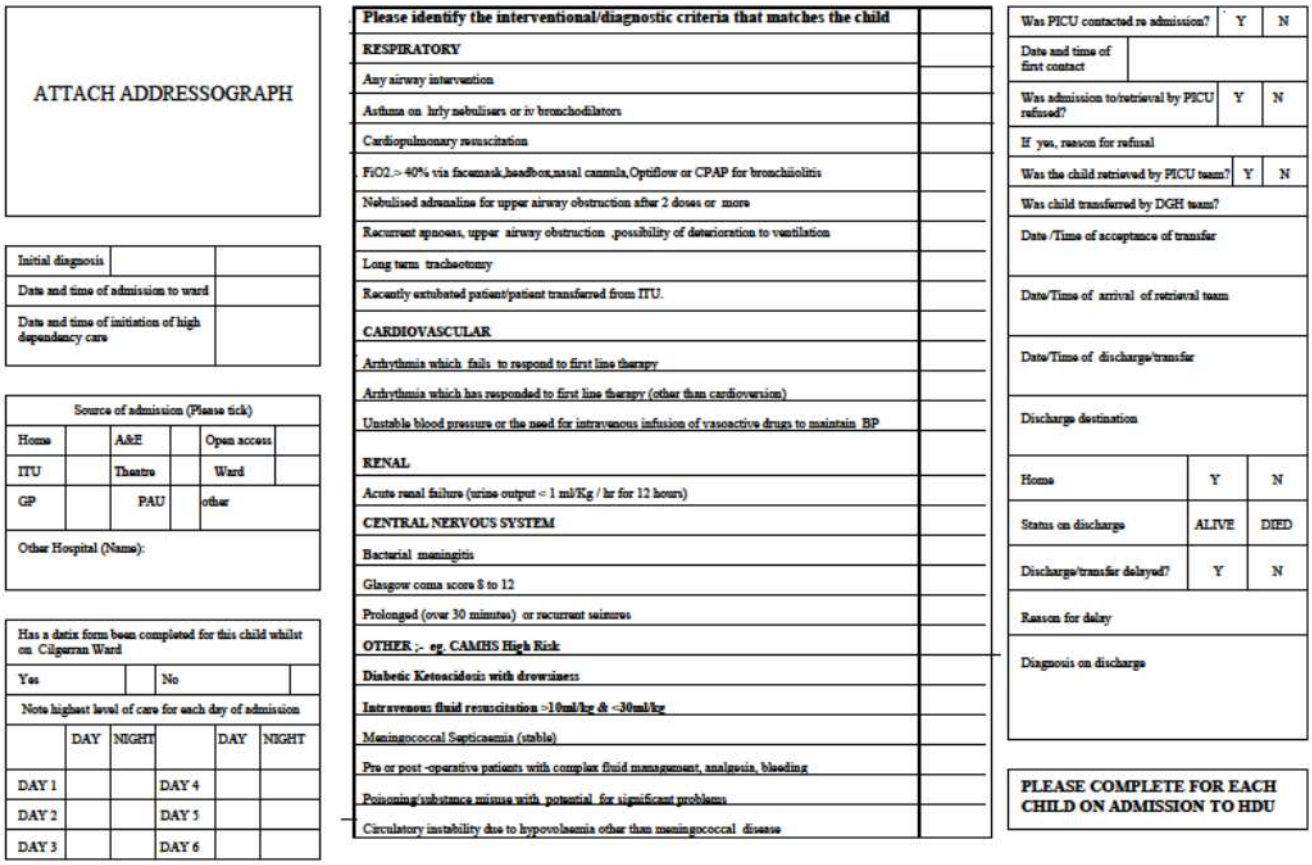
All Wales Universal Standards www.**wales**.nhs.uk/sites3/Documents/355/**All**%20**Wales**%20**Universal**%20... ·

Defining Staffing Levels for Children and Young People's Services RCN (2013). www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf

Quantifying high dependency care: a prospective cohort study in Yorkshire; Rushforth K et al; *European Journal of Paediatrics, 2012:* 171(1): 77-85

Standards for assessing, measuring and monitoring vital signs in infants, children and young people. RCN guidance for nurses working with children and young people (2013) www.**rcn**.org.uk/__data/assets/pdf_file/0004/114484/003196.pdf

11. Appendix 1 - data form



ATTACH ADDRESSOGRAPH

Initial diagnosis		
Date and time of admission to ward		
Date and time of initiation of high dependency care		

Source of admission (Please tick)					
Home		A&E		Open access	
ITU		Theatre		Ward	
GP		PAU		other	
Other Hospital (Name):					

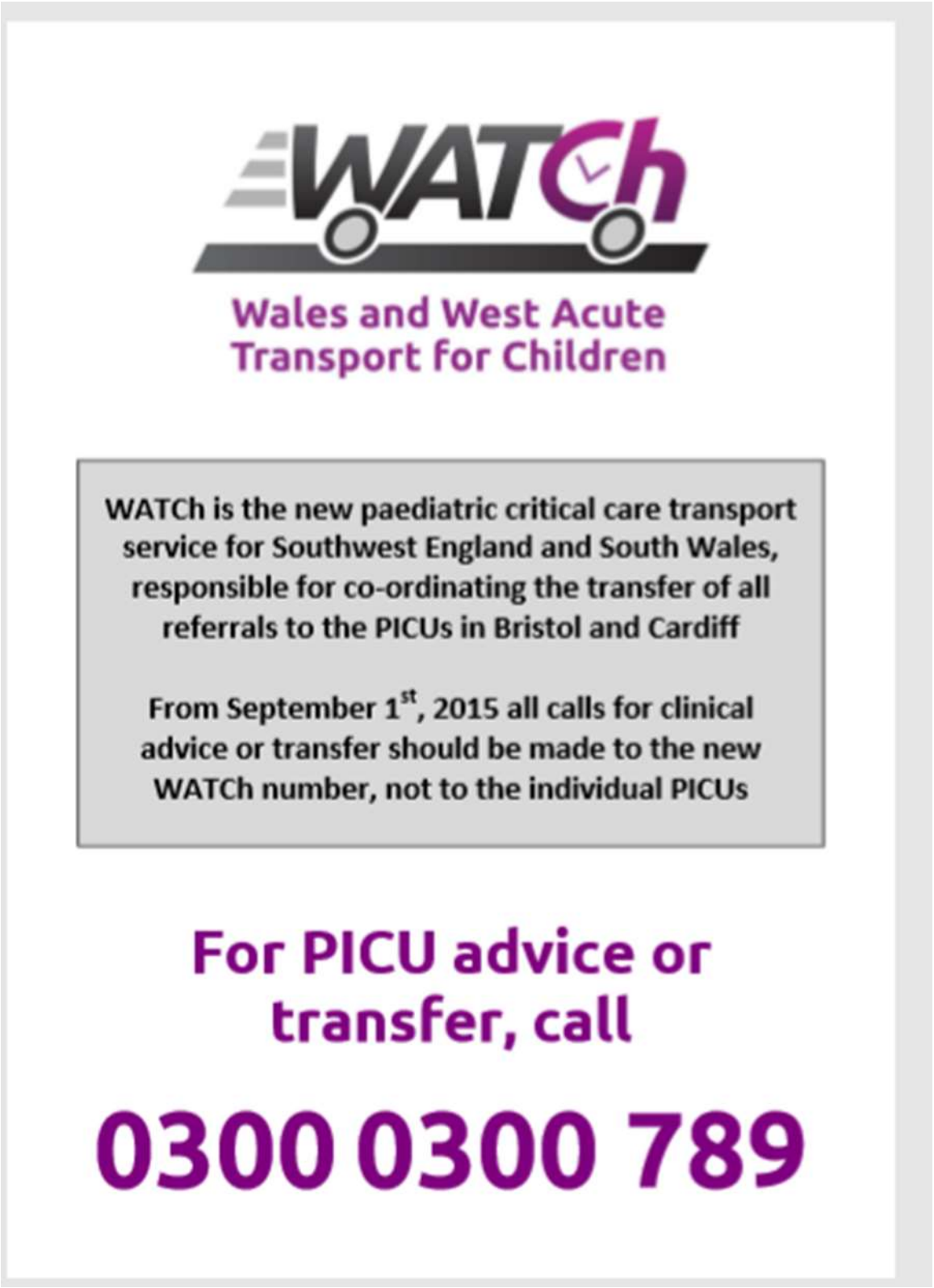
Has a datix form been completed for this child whilst on Cilgerran Ward					
Yes			No		
Note highest level of care for each day of admission					
	DAY	NIGHT		DAY	NIGHT
DAY 1			DAY 4		
DAY 2			DAY 5		
DAY 3			DAY 6		

Please identify the interventional/diagnostic criteria that matches the child	
RESPIRATORY	
Any airway intervention	
Asthma on hrly nebulisers or iv bronchodilators	
Cardiopulmonary resuscitation	
FiO2.> 40% via facemask,headbox,nasal cannula,Optiflow or CPAP for bronchiiolitis	
Nebulised adrenaline for upper airway obstruction after 2 doses or more	
Recurrent apnoeas, upper airway obstruction ,possibility of deterioration to ventilation	
Long term tracheotomy	
Recently extubated patient/patient transferred from ITU.	
CARDIOVASCULAR	
Arrhythmia which fails to respond to first line therapy	
Arrhythmia which has responded to first line therapy (other than cardioversion)	
Unstable blood pressure or the need for intravenous infusion of vasoactive drugs to maintain BP	
RENAL	
Acute renal failure (urine output < 1 ml/Kg / hr for 12 hours)	
CENTRAL NERVOUS SYSTEM	
Bacterial meningitis	
Glasgow coma score 8 to 12	
Prolonged (over 30 minutes) or recurrent seizures	
OTHER ;- eg. CAMHS High Risk	
Diabetic Ketoacidosis with drowsiness	
Intravenous fluid resuscitation >10ml/kg & <30ml/kg	
Meningococcal Septicaemia (stable)	
Pre or post -operative patients with complex fluid management, analgesia, bleeding	
Poisoning/substance misuse with potential for significant problems	
Circulatory instability due to hypovolaemia other than meningococcal disease	

Was PICU contacted re admission?	Y	N
Date and time of first contact		
Was admission to/retrieval by PICU refused?	Y	N
If yes, reason for refusal		
Was the child retrieved by PICU team?	Y	N
Was child transferred by DGH team?		
Date /Time of acceptance of transfer		
Date/Time of arrival of retrieval team		
Date/Time of discharge/transfer		
Discharge destination		
Home	Y	N
Status on discharge	ALIVE	DIED
Discharge/transfer delayed?	Y	N
Reason for delay		
Diagnosis on discharge		

PLEASE COMPLETE FOR EACH CHILD ON ADMISSION TO HDU

12. APPENDIX 2 – WATCh Poster



13. Appendix 3 - WATCH referral form

referral forms WATCh.pdf

14. Appendix 4 - Nursing Procedures for General Care Issues for the Paediatric High Dependency Unit (PHDU)

Women and Children's Directorate

1. Introduction

Children are entirely dependent upon their Nurses/Carers to provide for all their physical and emotional needs. There are a number of specific nursing care guidelines the nurse may use when caring for the acutely and critically ill child. However, it is important that the nurse is aware of some general care issues when caring for the infant/child /young person in PHDU.

2. Scope

This nursing procedural guideline is intended to be followed by nurses involved in caring for the highly dependent or critically ill infant child/young person within the PHDU at Hywel Dda University Health Board

3. Roles and responsibilities

All nursing staff involved in caring for infants or children in Paediatric High Dependency should be familiar with this nursing care guideline.

4. BODY PROCEDURE

Essential equipment (for each bed space):
Re-breathing set or ambubag & face mask – appropriate size
Wall oxygen, suction & tubing
Oxygen/air blender – where indicated
Suction catheters – correct sizes & Yankeurs
Spare portable oxygen cylinder (full)
Disposable aprons
Disposable sterile & non-sterile gloves
Alcohol hand gel/rub
Stethoscope
WOW trolley–stocked with items for all care and medicine administration
Cardiac monitor (with appropriate leads & disposables)
2 Fluid infusion pumps on drip stands and 4 syringe pumps on drip stand.
Workstation
Calculator
Appropriate paperwork for documentation
Folder for confidential records

PROCEDURE	RATIONALE
In PHDU each clinical nurse should perform a comprehensive, systematic assessment of his/her patient at the start of each shift. Assessment findings and patient status should be documented in the care plan evaluation and the integrated medical notes	Assessment of the patient following nursing handover is of critical importance in ensuring the nurse has effective knowledge about patients' baseline and current vital signs and in identifying patient need and priorities.
No infant or child's bed side or cubicle should be left unattended. *In High Dependency Unit: the nurse may have more than one child to care for, so should ensure it is safe to leave the bed side. If the nurse must leave the child's bed side or cubicle at any time (e.g. to assist in the care of another patient or during breaks) they must ensure that another nurse is able to observe the child.	Critically and acutely ill infants and children can deteriorate rapidly and may have life threatening changes in their condition, e.g may remove invasive lines, oxygen masks
If not carrying out a procedure at the bed side, the nurse must ensure that the cot sides or incubator safety shields are used. In specific patients ensure top & bottom of cots or beds are on as per the cot rails policy	To ensure patient safety and prevent accidental fall from bed or cot.
The nurse allocated each shift to care for an infant or child is responsible for the entire care of their patient, or patients, and acts to coordinate care with other health care professionals.	The caregiver, by assuming full responsibility for monitoring the infant or child's condition and care, can detect changes promptly.
Any breaks will be arranged according to the needs of the child, unit need and safe coverage of the unit. This will be by mutual agreement between each nurse and their co-workers.	When many people are involved in the care, a principal caregiver reduces the assumption that someone else did or did not complete a task, and helps to maximise resources.
The nurse must give a full report to another staff nurse prior to leaving for a break. The second nurse assumes responsibility for the infant or child and interacts with the family and other health team members in the principle nurse's absence.	To ensure the second nurse is aware of child's condition and treatment prior to assuming temporary responsibility for their care.
The nurse will report any deterioration in their patient's condition directly to the nurse-in-charge and the PHDU medical team.	The nurse caring for the infant/child is the one person who has current and detailed information on the infant or child's condition.
The nurse will ensure that the nurse-in-charge is kept informed of all laboratory reports and of any ongoing changes in their patient's condition.	The nurse-in-charge has overall responsibility for the care given to all patients in the PHDU. They may be able to support the other nurse in patient care, especially with regard to any appropriate procedure, policy or physician interaction required.
The bed space area will be kept clean, dry and free from clutter. Equipment will be in good working order and any broken items will be removed, labelled and reported.	To help maintain safe environment and reduce risks to the patient, visitors and staff.
Each bed space must have functioning wall oxygen, air and suction equipment. This must be checked each shift and documented by the nursing staff.	To ensure working oxygen, air and suction equipment available for either routine or emergency airway care.

Monitoring: All monitors and monitor alarm limits must be checked at least once each shift by the staff nurse caring for the infant or child. This must be documented. Specific monitoring: e.g. ECG, SpO2, temperature, please refer to separate specific monitoring guideline(s).	Unless specifically directed all acutely and critically ill infants and children will require some form of monitoring of their overall condition. Checking and setting appropriate alarm limits can help detect changes in child's condition. Refer to separate specific monitoring guideline(s).
Specific nursing procedures & care: e.g. Eye/mouth, skin & pressure area care, suction, chest drain.	Refer to separate specific care guideline(s).