

Paediatric Intensive Care Unit

Paediatric Admission & Discharge Criteria to CICU & PICU

Staff relevant to:	CICU or PICU
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Contents

1. Introduction and Who Guideline applies to	2
2. Admission Criteria.....	2
2.1 Discharge Criteria:	2
Discharge Criteria.....	2
Suitability for transfer/discharge will be based on the following:.....	2
Categories of Discharge	3
2.2 Further considerations:	3
2.3 Discharge Procedure:	4
When discharging to ward:	4
When discharging a patient to another hospital:	4
Long Term Patients:	4
Access to Regional Specialist Services:.....	5
2.4 Roles & Responsibilities:.....	5
2.5 Handover of Care:.....	5
3. Education and Training	6
4. Monitoring Compliance	6
5. Supporting References	6
6. Key Words	7
Contact & review details	7
Appendix 1: Flow chart for discharge from PICU	8

1. Introduction and who this guideline applies to

The following document provides a framework for all admissions and discharges to the Children's Intensive Care Unit (CICU) and the Cardiac Paediatric Intensive Care Unit (CPICU). This document only applies to patients admitted or discharged from CICU or CPICU. The document should also apply to inter-unit transfers as the different sites make it important to have documented evidence of handover.

2. Admission criteria:

- All admissions to CICU/CPICU must be approved by the duty PIC consultant
- All admissions must have an admitting parent specialty consultant
- Referrals to CICU/CPICU should be consultant to consultant when at all possible

2.1 Discharge criteria:

- All discharges from CICU/PICU must be approved by the duty PIC consultant
- The parent specialty team/Consultant should be informed of the discharge
- All patients should be accompanied by a discharge summary, which should be verified by the Consultant within 24 hours

Discharge Criteria

- Potential discharges should be identified at each ward round.
- Children will be identified by the PIC team as approaching "ready for discharge" status. (08:30h, 16:00h, and 20:30 h).
- Patients in the CICU/CPICU should be evaluated and considered for discharge based on the reversal of the disease process or resolution of the unstable physiologic condition that prompted admission to the unit, and when it is determined that the need for complex intervention exceeding general patient care unit capabilities is no longer needed. Suitable area for transfer (e.g. HDU/cubicle/ ward) will be identified as per their clinical requirement.
- Patients identified as suitable for step down should be identified as such on NerveCentre, selecting "Children's – Step Down" under the Children's Discharge heading.

Suitability for transfer/discharge will be based on the following:

1. Stable haemodynamic parameters (heart rate, blood pressure, and perfusion).
2. Stable respiratory status (patient extubated with stable blood gases) and airway patency.

3. Minimal oxygen requirements that do not exceed ward or HDU guidelines.
4. Intravenous inotropic support, vasodilators, and antiarrhythmic drugs are no longer required or, when applicable, low doses of these medications can be administered safely in otherwise stable patients in a ward or HDU.
5. Cardiac dysrhythmias are controlled.
6. Neurologic stability with control of seizures.
7. Chronically mechanically ventilated patients whose critical illness has been reversed or resolved and who are otherwise stable may be discharged to a ward or to HDU if they continue to need the same level of respiratory support as before while they were at home.
8. Routine peritoneal or haemodialysis with resolution of critical illness not exceeding ward guidelines.
9. The health care team and the patient's family, after careful assessment, determine that there is no benefit in keeping the child in the CICU / PICU or that the course of treatment is medically futile.

Categories of Discharge

- **Category 1 Routine.** Critical Care has a least one available bed. Patients will be discharged within **4** hours.
- **Category 2 Urgent.** Critical care areas have no available space i.e. reached capacity. Patients will be discharged within **2** hours
- **Category 3 Time Critical*.** Critical Care has no available space and a critically ill patient requires immediate admission. Patient will be discharged **as quickly as possible**.

*This situation is not desirable and may result in a compromise to patient safety.

2.2 Further considerations:

All discharge summaries should be reviewed and signed by the duty consultant prior to discharge. If this is not possible they should be presented to the duty consultant within 24 hrs.

Discharge summaries should be started and updated by the night shift team and completed after the consultant ward round.

Patients *should not* be discharged overnight (between 20:00 and 08:00) without specific approval of the duty PIC consultant and parent specialty team.

In all cases ensure management plan is communicated clearly and child protection procedures or concerns must be specifically detailed. Handover should be conducted verbally between teams to support the information within the CICU/CPICU discharge letter.

It is a rare occurrence for a child to be discharged home straight from CICU/CPICU and should only be done with the specific approval of the duty PIC consultant and parent specialty team.

The final decision to discharge should be confirmed by the CICU/CPICU duty consultant and

parent specialty team.

2.3 Discharge Procedure:

Timing of patient discharge from critical care impacts on the outcome of the patient.

Poor planning may result in disruption of care, delayed recovery and high readmission rates.

It has been shown that discharge at night increases patient mortality. It has been recommended that transfer from critical care areas to the general ward between 20:00 and 08:00 should be avoided and documented as an adverse event if it occurs.

When discharging to ward:

1. Inform the bed co-ordinator of the discharge
2. Inform parent specialty team of imminent discharge
3. Complete the discharge summary
4. Print discharge summary letter to accompany patient ensure signed by consultant. Copy to the GP and referring hospital.
5. Perform clinical review & early warning score immediately prior to discharge to confirm suitability
6. CICU/CPICU nurse to handover to ward nurse

When discharging a patient to another hospital:

1. Discuss with PIC consultant and parent specialty team
2. Inform PIC nurse in charge of anticipated need for transfer arrangements
3. Inform accepting hospital consultant
4. Inform GP when transfer is to a hospice
5. Inform accepting ward nurse in charge
6. Complete the discharge summary and ensure plans are clearly documented especially drain/central line removal
7. Print discharge summary letter to accompany patient, ensure signed off by consultant. Copy to the GP and referring hospital.
8. Perform clinical review & early warning score immediately prior to discharge to confirm suitability
9. Appropriate transfer team/nurse to accompany patient

Long Term Patients:

The discharge of any patient from critical care involves planning however it is especially important to plan the discharge of long term or complex patients. Defining this group is difficult but should include all patients who have required critical care for greater than 2 weeks. Patients, their relatives and ward staff all need time to prepare for the discharge. Specific needs must be identified as soon as practical. Specialist services will need time to co-ordinate all aspects required for continuing care. This may take several days but the process should start before they are ready for discharge in order to ensure that a timely discharge from critical care.

Access to Regional Specialist Services:

If a specialist service is commissioned in the critical care unit, it may be necessary to discharge patients to another critical care unit if they are not able to transition from critical care if the specialist service is no longer required. It is essential that regional specialist services are protected by avoiding any undue delay in discharge.

The possibility of discharge to another critical care facility needs not only agreement between the PIC Consultants but also agreement of the referring team in the Tertiary Centre and in the non-specialist unit. The patient's requirements are paramount to any change of facility.

2.4 Roles & Responsibilities:

Medical Staff

The final decision that a patient is fit for discharge/step down from critical care remains with the critical care consultant. It is essential that the parent team (or their representative out of hours) is aware of all discharges.

Nursing Staff

It is the nursing staff's responsibility to ensure a safe and timely discharge of a patient from critical care areas once a bed has been identified. Unless there is an immediate threat to capacity on the critical care unit, discharges must not occur within the hours of 20:00 and 08:00. They must also ensure all documentation is complete to accompany the patient. For patients with complex needs and those classed as long term patients, the nurse in charge of the receiving area must ensure that a face to face handover has been obtained whilst in the critical care unit.

Bed Co-ordinator

It is the responsibility of the bed co-ordinator to ensure identification of an appropriate bed in conjunction with key stakeholders and within the timescale appropriate for the capacity of the critical care area. Patients should be cared for in the most appropriate setting and maximise availability of critical care capacity.

2.5 Handover of Care:

The discharging team and the receiving team both have a responsibility to ensure the appropriate care of the patient being discharged. They should ensure:

- There is continuity of care facilitated by a formal structured handover of care from critical care area staff to ward staff (including both medical and nursing staff), supported by a written plan.
- That the receiving ward, with support from critical care if required, can deliver the agreed plan.

When patients are transferred to the general ward from a critical care area, they and their parents/carers should be offered information about their condition and encouraged to actively participate in decisions that relate to their recovery. Safety net information and advice should

be included, as well as information about who to contact in case of issues. The information should be tailored to individual circumstances. Where possible and if required, information should be given in language that families understand, if necessary using available translation services.

A Structured Handover Must Include:

- A summary of the critical care stay, including diagnosis and treatment and a full history of any long term and complex needs the child may have.
- A monitoring and investigation plan
- An escalation plan should deterioration of the child occur
- A plan for on-going treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment.
- Physical and rehabilitation needs

It is essential to give a detailed review of medication. Treatment to be reviewed or stopped must be clearly identified, as must the timing. Long term medications must be also considered. If these have been changed or not yet restarted this must be documented.

If there are any variations or changes to any part of the discharge plan, this should be clearly documented in the medical notes

3. Education and Training

There is no new training required to implement this guideline

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Discharges between 20:00 and 08:00	Regular audit	J Whitelaw, Consultant J Wilson, Matron	Yearly	QUICKA
Delayed discharges	Regular audit	J Whitelaw, Consultant J Wilson, Matron	Yearly	QUICKA

5. Supporting References

Admission and discharge guidelines for the pediatric patient requiring intermediate care: David G. Jaimovich, MD; and the Committee on Hospital Care and Section on Critical Care, Crit Care Med 2004 Vol. 32, No. 5

Admission to PICU: Guidelines for Intensive Care and High Dependency Patients: The Children's Hospital at Westmead Policy

Paediatric Critical Care Society (2021) Quality Standards for the Care of Critically Ill or Injured Children (6th ed.) <https://pccsociety.uk/wp-content/uploads/2021/10/PCCS-Standards-2021.pdf>

Acutely ill patients in hospital Recognition of and response to acute illness in adults in hospital National Institute for Health and Clinical Excellence July2007

Quality Critical Care, Beyond ‘Comprehensive Critical Care’ September 2005

6. Key Words

Admission, Discharge, Criteria, CPICU, CICU

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Contact & review details	
Guideline Lead (Name and Title) J. Whitelaw - Consultant Paediatric Intensivist	Executive Lead Chief Nurse
Details of Changes made during review: <ul style="list-style-type: none"> • Included reference to identifying patients suitable for “Children’s – Step Down” on NerveCentre . • Added to section 2.2, further considerations ‘handover should be conducted verbally between teams to support the info within the discharge letter. • Removed reference to ward 30 • Discharges must not occur within the hours 20:00-08:00 (previously 20:00-07:00) unless there is an immediate threat to capacity on critical care. • Handover of care, added to provide safety net info, contact info and consider translation services. • Added monitoring compliance • Updated references 	

Appendix 1: Flow chart for discharge from PICU

Flow Chart for Discharge from PICU

