South Thames Paediatric Network
Transforming Healthcare for Children and Young People

Admission Criteria Recommendations for designated Level 2 Centres

Introduction

The following is a guide for children requiring admission for paediatric critical care, whether electively or in an acute presentation. Admission is primarily for the care of a critically ill child, or a child requiring long term ventilation (LTV).

Any admissions outside the following guidelines must be discussed with the consultant responsible for Paediatric Critical Care (PCC) and Senior Paediatric Nursing team.

Paediatric Early Warning Systems (PEWS) contribute to the identification of the sick or deteriorating child and help to ensure appropriate escalation. In itself, an elevated PEWS score is not an admission criteria to PCC**, but there should be a low threshold for discussing these patients with the PCC team.**

Level 2 beds should be prioritised for children requiring Level 2 Critical care as defined by PCCS standards (2021).

The admission criteria recommended below may require adaptation between providers, in order to suit the local patient population, and may require additional training and development for staff, and therefore may be achieved in stages within a provider (GIRFT 2022).

All admissions to Paediatric Critical Care need to be reviewed by a Senior Clinician within an hour of admission and must be discussed with a Consultant. Timeline of this discussion will depend on competence and expertise of senior clinician but should occur with Consultant on duty at time of admission before change of responsibility, this discussion may be virtual however all patient must be reviewed by a consultant within 14 hours (PCCS2021).

Recommended Admission Criteria (Based on PCCS 2021)

Airway

- Nasopharyngeal airway

Breathing

- Acute Non-invasive Ventilation including CPAP & BiPAP (excluding treatment of Bronchiolitis in under 2s)
- CPAP or BiPAP for established LTV patents *
- Long Term Ventilation via an established Tracheostomy *

Diagnosis

- Status Epilepticus requiring treatment with continuous IV infusions

Other

- Epidural infusions (If required by centre with relevant local training)

CAUTION for centres not co-located with PICUs or specialist services.

Only Centres with appropriate **expertise & experience** managing these scenarios should consider treatment for a limited time period and **all must be discussed** with retrieval team:

Vasoactive infusions

Invasive Arterial Monitoring

Central Venous Pressure Monitoring

CPR in previous 24 hours

>80mls/kg Volume bolus

Exchange Transfusion

EXCLUSIONS for centres not co-located with PICUs, Neurospeciality, Hepatology services or a Specialist renal centre:

Care of Tracheostomies (First seven days of insertion episode only)

Temporary external pacing

Hemofiltration or dialysis

Intracranial Monitoring / External ventricular drain

Intravenous Thrombolysis

Extracorporeal liver Support (MARS)

Plasmafiltration

Prioritising beds

- Beds should be prioritised at all times for children requiring Level 2 PCC as above
- Remaining beds can be used for children requiring Level 1 PCC including (PCCS 2021):
    - Upper airway Obstruction requiring nebulised adrenaline
    - Apnoea – recurrent
    - Oxygen or nasal High Flow Therapy plus continuous pulse Oximetry and ECG monitoring
    - Arrythmias requiring IV anti- arrhythmic therapy
    - Severe asthma requiring infused bronchodilator / continuous nebulisers

    - Diabetic Ketoacidosis requiring continuous insulin infusion
    - Reduced level of consciousness (GCS 12 or below) and hourly (or more frequent) GCS monitoring
- All **Level 1** Paediatric Critical Care patients should be reviewed by a **Senior Clinician**, prior to admission and discussed with a **Consultant** and the **retrieval team** as appropriate (PCCS 2021).
- Should beds be filled by **Level 1 patients,** then the most stable should be moved to the main ward to make space for **L2 admissions.**

There may be interventions that do not usually meet Level 2 thresholds but will require careful consideration and management within PCC, for example Chest drains and PCC patients that are not responding to treatment **within 24 hours**.

*Long Term Ventilation

- LTV Patients may be admitted through a variety of pathways including acutely and as tertiary centre step downs. Considerations may be required to where these patients are cared for whilst awaiting care packages and/or family and carer training is in place and may move from acute Level 2 beds with appropriate staffing, training and support when not acutely unwell. This decision must involve the whole Multidisciplinary team.
- Consideration of whether LTV patient is admitted due to an acute presentation or routine investigations or step down will also be required when allocating staff appropriately.
- Respiratory Action Plans should always be referred to and patients should be discussed with their LTV centre as appropriate.
- Please refer to Network LTV Guideline (2023).

Escalation

Usual escalation pathways and processes should be followed for all Paediatric Critical Care patients and there should be a low threshold for discussion of Level 2 Patients with retrieval services as well as those Level 0-1 patients who are not responding to treatment as expected and/or the requirement for intervention persists for >**24 hours.**

References

GIRFT (2021) Paediatric Critical Care GIRFT Programme National Specialty Report Available: Paediatric Critical Care GIRFT (2022) [accessed June 2023]

PCCS (2021) Paediatric Critical Care Society Quality Standards 6th Edition Available: Paediatric Intensive Care Society - Standards 2021 [accessed June 2023]