HDU provision Ash Ward ASPH NHS Foundation Trust

LEVEL 1 PCC

Expected interventions:

AIRWAY:

Care of child with airway pathology with anaesthetic team support;

Intubation and ventilation of child or baby awaiting retrieval;

Management of the unventilated child with tracheostomy;

BREATHING:

Severe asthma – IV bronchodilators or continuous nebulisers with full monitoring;

Deliver CPAP < 1 yr;

Deliver high flow oxygen via Vapotherm or Optiflow < 2 yrs;

Chest Physiotherapy for respiratory diseases;

Apnoea requiring intervention in past 24 hours;

Severe croup requiring adrenaline nebulisers;

Chest drain in situ – with or without being under pressure.

CIRCULATION:

Resuscitation and initiation of inotropes;

Establishment of arterial monitoring and central monitoring with anaesthetic support while awaiting retrieval;

Continuous appropriate monitoring for shocked children;

Arrhythmia due to SVT that responds to adenosine and is now controlled, with cardiac support from Royal Brompton Hospital;

Detailed fluid balance recording measuring strict input and output either continuously or hourly; including children who are catheterised and who have deranged renal function.

NEUROLOGY:

IV anticonvulsant loading to terminate seizures;

Care of un-intubated child recovering from status epilepticus;

Care of intubated child recovering from status epilepticus awaiting retrieval;

Care of temporarily intubated child now extubated recovering from status epilepticus;

Resuscitation and management of child with altered level of consciousness;

Raised ICP including use of IV mannitol or hypertonic saline, with support from St Georges neurology/neurosurgery teams.

ENDOCRINE/METABOLIC:

DKA as per national guidelines with IV insulin and careful adherence to local ICP;

Management of acute deterioration in long standing endocrine or metabolic condition according to their personal care plan.

Parvolex infusion for management of paracetamol overdose with levels in treatment zone.

SURGERY:

Post-op child with mild cardiovascular instability requiring fluids but not inotropes;

Child requiring dedicated pain service including PCA;

Administration of TPN via PICC line.

Expected medical input:

To be seen daily by the attending consultant on morning ward round;

To be seen by either the attending consultant or the on call consultant in the evening;

To be reviewed by registrar or above at any time the nursing staff feel there has been a deterioration;

Care to be escalated via STRS or stepped down to main ward as soon as medical condition dictates; decision to be made by consultant.

Expected nursing input:

1:2 ratio;

Attend every ward round review;

HDU nursing station in old cubicle 4;

Central monitoring as required;

Completion of PEWS escalation criteria chart;

All observations charts to be kept at the bed space;

Any deterioration in condition escalate to registrar or above as well as the nurse in charge.

HDU link consultant – Kate Irwin

HDU link nurse – Emily Carr

References:

High dependency care for children: A time to move on RCPCH 2014

Facing the future; standards for paediatric care RCPCH 2018

PCC provision recommendations NHS London

July 2019 Dr Kate Irwin