Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

STANDARD OPERATING PROCEDURE

TITLE: Level 2 Paediatric Critical Care Unit – Ash Ward	
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PURPOSE

The Standard Operating Procedure is to provide guidance for staff admitting and managing paediatric patients in the Level 2 Paediatric Critical care unit (PCCU) to ensure a consistent approach.

The aims of the PCCU are:

- To improve the quality of care for patients with Long Term Ventilation (LTV) needs requiring inpatient stay close to their home.
- To provide an enhanced care area to look after critically unwell patients requiring level 1 and level 2 respiratory paediatric critical care.
- To maximise effective and efficient use of available resources to support staff in looking after PCCU patients.
- To enhance training and experience required for all staff members in paediatric critical care (PCC) including medical, nursing & allied health professionals (AHPs)
- To ensure that patients and their families have support locally with input from the multidisciplinary team
- To ensure that families and carers have the training they require to enable them to look after their Child/Young person both in hospital and in the community when they go home.

Paediatric Critical Care (PCC) is the provision of close observation, monitoring and therapies to children who are, or have a significant potential to be, physiologically unstable which is beyond the capability of a general paediatric ward. Entry into PCC is governed by the degree of physiological instability as much as by diagnosis.

Level 2 PCCUs may be specialist or non-specialist and are provided in tertiary hospitals and a limited number of DGHs and will deliver level 1 & 2 care. These were formerly classified as HDUs (commissioned by NHS England).

Across England, 8-10% of children admitted to hospital require high dependency care (HDC). The current children's inpatient unit delivery L1 basic high dependency care and L0 ward level care. This is expected of every hospital that admits children and is commissioned by the local integrated care board. Setting up a respiratory critical care unit will allow deliver of intermediate L2 high dependency care.

Advancements in neonatal care, technology and outcomes have led to an exponential increase in the numbers of children and young people (CYP) with LTV needs. These CYP require careful support and supervision and are at an increased risk of becoming unwell. This can place an increased demand on regional Paediatric Intensive & Critical Care Centre's. The establishment of a PCCU (Level 2) at Ashford and St Peter's aims to help address this need.
This Service aims to provide high quality Paediatric Critical Care which meets the standards set out in national guidance as close to home as possible for:

• Critically ill children whose severity of illness does not require acute invasive ventilation or specialist care.

• The care of long-term ventilated children, during treatment of episodes of inter-current illness.

The criteria have been adjusted, as advised in the guidance, to fit the context of our Paediatric Critical Care Unit. Criteria for consideration of level 2 critical care are detailed on **pages 3 and 4**. For the rest of the SOP this level of care will be referred to as Level 2 care. The guidance addresses transitions of care including referral and stepdown pathways relevant for admissions, discharges and escalation of care.

This service is commissioned by NHS England.

AIM

To provide a standard Trust-wide pathway that ensures all patients requiring level 2 are cared for appropriately as per Paediatric Intensive Care Society Quality standards for the care of Critically Ill or Injured Children (2021)

The aims are:

- To ensure that there is safe transition between wards, departments and hospitals with the appropriate escort to minimise patient risk.
- Clear ownership of roles and responsibilities
- Standardised practice

SCOPE

The PCCU is situated on Ash Ward which is a 20-bedded ward inclusive of PCCU beds, of which includes one Level 2 beds and two Level 1 beds

The SOP applies to all clinical and managerial staff involved in the care and management of acute paediatric patients within ASPH.

COMPETENCIES

Understanding of Trust policies and protocols

Detailed clinical and professional knowledge

National Paediatric Critical Care Nursing Competencies

GLOSSARY

- **ASPH** – Ashford and St Peter's Hospital NHS Trust
- **BiPAP** – Bi-level Positive Airway Pressure
- **CPAP** – Continuous Positive Airway Pressure
- **CYP** – Children and young people
- **ED** – Emergency Department
- **ENT** - Ear, Nose & Thraot
- **HDU** – High Dependency Unit
- **ITU** – Intensive Therapy Unit
- **L1** – Level One
- **L2** – Level Two
- **L3** – Level Three
- **LTV** – Long Term Ventilation
- **NIC** – Nurse in Charge

- **NIV** – Non-Invasive Ventilation
- **NPA** – Nasopharyngeal Airway
- **PEWS** – Paediatrics Early Warning Score
- **PCCS** – Paediatric Critical Care Society
- **PCCU** – Paediatric Critical Care Unit
- **PICU** – Paediatric Intensive Care Unit
- **SOP** – Standard Operating Procedure
- **STOPP** – Safe Transfer of the Paediatric Patient
- **STRS** – South Thames Retrieval Service
- **STPN** – South Thames Paediatric Network

PROCESS

General principles

Admission to PCCU is the responsibility of the on-call lead Consultant. All referrals to Ash Ward Paediatric PCCU in normal working hours must be discussed with the Consultant accepting the patient and the Nurse in Charge (NIC). Out of hours, all referrals must be discussed with the Paediatric Consultant and NIC.

The lead Paediatric Consultant must be informed of all children who deteriorate on PCCU and prior to referral to PICU for an opinion.

Step down to a general medical ward bed from PCCU must be planned and timely. This should be agreed by the Paediatric Registrar and NIC.

There should be daily Trust and Regional discussions regarding Paediatric beds, including PCCU escalation and de-escalations.

Admission criteria to PCCU are in line with the principles outlined in the Time to Move On document 2014[1], Paediatric Intensive Care Society Quality standards for the care of Critically Ill or Injured Children 2021[2], South Thames Paediatric Network and the Children and Young People's Safer Nursing Care Tool (C&YP SNCT).

We will care for patients up to their 16th birthday, unless they have not yet transitioned to adult services and remain under the care of a local paediatric respiratory consultant or if there are extenuating circumstances, e.g. if they are on a palliative care pathway and likely to deteriorate suddenly.

Referral for admission to Ash Ward Paediatric PCCU

- Consider any patient who a Paediatric Consultant, Nurse or Ward Sister has clinically assessed to require PCCU care (Level 1 or Level 2)
- These beds should be prioritised for children requiring respiratory Level 2 paediatric critical care (PCC), as defined by PCCS standards (2021) and Healthy London Partnership standards (2016.)

- LTV children may be admitted from home or stepped down from a tertiary centre, they already have a continuing care package, and all relevant training is completed.
- Children who require acute NIV may be admitted from the emergency department (ED) or may already be inpatients on the ward receiving L0 or L1 care.
- Inclusion and exclusion criteria are outlined below. These will be subject to regular review as part of the governance of the unit.
- The PCCU will look after children with LTV (both CPAP and BiPAP delivered via facemask *or tracheostomy*) and acute CPAP. In exceptional circumstances, initiation of BiPAP acutely will be on a patient-by -patient basis. This will need to be discussed and agreed with STRS as transfer to a Level 3 may be preferable. It will also need to be agreed to by the paediatric consultant and paediatric matron. The exception is BiPAP for palliation. This needs to be agreed by the paediatric consultant, paediatric nurse in charge/matron and child's palliative care team.

LEVEL 1: BASIC CRITICAL CARE

Airway:

- Upper airway obstruction requiring nebulised adrenaline
- Established nasopharyngeal airway
- Management of unventilated child with tracheostomy (>7days post procedure)
- Intubation and ventilation of child or baby in an emergency until retrieval team arrives

Breathing:

- Apnoea – recurrent and requiring intervention in past 24hrs
- Oxygen or nasal high flow therapy plus continuous pulse oximetry and ECG monitoring
- Delivery of CPAP <2yr
- Severe asthma requiring IV bronchodilators or continuous nebulisers with full monitoring

Circulation:

- Arrhythmia due to SVT requiring IV anti-arrhythmic therapy
- Monitoring of shocked children who achieve cardiovascular stability after fluid resuscitation (and do not require inotropes)
- Initiation of inotropes whilst awaiting retrieval to Level 2 or 3 critical care

Disability

- Reduced level of consciousness (GCS ≤12) and hourly neuro-observations
- IV anticonvulsants to stop seizures
- Care of child recovering from status epilepticus (un-intubated, including extubated locally)
- Care of intubated child recovering from status epilepticus awaiting retrieval
- Initial resuscitation and management of child with altered level of consciousness, raised intracranial pressure, post head injury (e.g. requiring hypertonic saline bolus) until transferred out

Endocrine/Electrolyte/Metabolic

- Diabetic ketoacidosis requiring continuous insulin infusion
- Acute deterioration of long-term endocrine and metabolic conditions where there is a clear individual patient management plan in place
- Complex IV fluid balance management
    - Specialised fluids (e.g. human albumin solution, IVIg)
    - Replacement fluids (e.g. surgical or gastroenterological patients)
    - IV electrolyte management
    - Renal impairment

Other:

- Patient controlled analgesia (PCA)

LEVEL TWO (Admission Criteria set out by ASPH)

LTV - step down:

- Step-down of LTV from tertiary centres once LTV has been fully established and package of care has been established. All LTV patients must have been home before; we will not be accepting patients to establish the training needs or package of care.

For those children being stepped down from a tertiary centre, a repatriation checklist will be completed before admission to give clarity of needs and equipment so that this can be organised/arranged prior to arrival and assessment of suitability made. This will be co-ordinated by the clinical nurse specialists or discharge co-ordinator at the referring unit.

LTV – acutely unwell:

- LTV patients presenting acutely to ASPH emergency department requiring admission as per escalation of home care plan. Any Level 3 care will need Tertiary care transfer.

- LTV patients presenting acutely to ASPH emergency department who require admission and are stable for transfer to the ward as per STOPP tool +/- discussion with STRS)

Non-LTV

- Patients requiring acute CPAP for any indication (Over the age of 2 years)
- Patients with nasopharyngeal airways already in situ in the community.

For those children on LTV, their respiratory action plans should be referred to. These are available both as paper copies in the notes and on the electronic patient records. Admitted LTV patients will be discussed with their LTV centre as appropriate.

Although all actions will be taken to provide appropriate care for all patients, if patients are deteriorating and require level 3 PCC, they will be referred via the existing network pathway for advice and potential transfer to a L3 PCCU. This service is provided by the South Thames Retrieval Service.

Those patients not responding to treatment as expected will also be discussed.

Exclusion criteria

Children requiring:

- inotropic support,
- Arterial lines, femoral/neck lines
- continuous benzodiazepine infusions,
- exchange transfusion
- chest drain insitu
- Patients over 16 years of age (unless pre-agreed)
- Any Level 3 patients
- A patient requiring Level 2 care from another DGH
- Acute tracheostomy concerns
    - Which require daily ENT review e.g. granuloma, stoma breakdown
    - Requiring ENT review 24hrs
- Newly established home long term ventilation
    - First step down from level 3 critical care/tertiary centre following LTV initiation (including no OOH transfers between Fri 12pm – Mon 9am)
    - Not yet discharged home on long term ventilation
    - Community care not set up (carers, training – including parents, funding, home and social environment)
- Long term ventilation above unwell settings
    - Exceeding sick pressure settings
    - Exceeding 4L oxygen
    - Requiring inpatient physiotherapy or mucolytic nebulisers >3x/day

The unit will not deliver L3 advanced critical care (e.g. invasive mechanical ventilation). Children requiring L3 critical care will be transferred to PICU as per existing pathways.

The unit will not be delivering inotropic support (which is classed as L2 care). Children requiring inotropic support will be transferred to PICU as per existing pathways.

For flow charts regarding admission to Ash ward L2 PCCU from other areas at ASPH and a Level 3 stepdown please see linked processes.

[1]Patients should be considered as complex if length of hospital stay is >2weeks and >2 clinical teams involved or social complexity including complex safeguarding or conflict that has threatened to impact care. These are general rules, and the definition is at the discretion of the clinical team.

[2] Multi-disciplinary team meeting should be arranged for all complex patients/LTV pre-discharge. MDT meeting should include all relevant medical and therapy teams involved in care as well as representation from PICU and Ash ward management

[3]Set expectations to families/parents/carers prior to transfer of the different environment and level of care; including ratios of nursing staff to patients is likely to be 1:2-1:3 in PCCU, unless clinically deemed otherwise.

[4]In hours reflective of medical and nursing day shifts

Escalation of Care to Level 2 and Level 3 Paediatric Critical Care (PICU)

A referral should be made to PICU as soon as is reasonably possible via the STRS line

(020 7188 5000).

Patients who are critically unwell and deteriorating will be assessed and discussed with STRS +/- the tertiary specialty team/s.

These include but are not limited to:

- LTV patients who are significantly above the oxygen and/or pressure settings of their normal sick day plan
- Patients on non-invasive ventilation requiring intubation and ventilation/new onset BiPAP
- Any deteriorating child requiring multi-organ support as per existing pathways for any child that presents to ED or deteriorates on Ash ward

Short term ventilation support whilst awaiting transfer

Should short term ventilation support be required for a patient, a decision will be undertaken by the paediatric team re intubation and ventilation with assistance from Anesthetics to facilitate this. Support should be sought fr

om STRS and retrieval arranged. This should follow the current pathway and working agreements in place for any child that comes through ED requiring intubation and ventilation.

Any patient who requires an acute escalation of care should be appropriately stabilised prior to transfer by the ward and anaesthetic team (as needed), with support from the ITU, critical care outreach team and bleep holders.

This *may* include intubation and ventilation, commencement of peripheral inotropes and central line insertion as appropriate.

Patient review

Admissions to PCC will be reviewed by a senior clinician within an hour of admission and discussed with a consultant. The timing of admission and discussion will depend on the experience of the clinician but should occur with the consultant on duty at the time before a change of responsibility. This discussion may be virtual. The patient should have a consultant review within 14 hours (PCCS 2021).

Patients will be seen on the PCCU ward roundMonday to Friday twice daily by a consultant or middle grade doctor.

PCCU patients will be discussed in morning and evening handovers.

Patients with an acute respiratory deterioration will be seen at least daily by the PCCU physiotherapy team Monday to Friday. During out of hours, the on-call physiotherapy team can be contacted and will attend if necessary. Weekend therapy input will be based on clinical need and planned in advance if deemed necessary by the physiotherapist team.

Discussions with the patient specific tertiary teams will occur as required.

Handover to the weekend team will happen during Grand round to ensure plans are in place for all current PCCU patients.

SBAR (Situation, Background, Assessment, Recommendation) handover tool should be used for handover between staff/clinical areas.

Out-of-hours cover is provided by the paediatric team and on call paediatric consultant.

LTV clinic will run once a month led by the consultant. There will be input from the PCC Co-Ordinator, and AHPs (*including physiotherapy, speech and language therapy, dietician etc.).*

Discharge

Discharge from PCCU beds should be safe and timely to ensure adequate flow of patients.

Any perceived delay to discharge must be escalated to the NIC as soon as identified.

Criteria for stepdown from PCCU include:

- No longer requiring Level 2 Paediatric Critical Care interventions
- Stable respiratory status with FiO2 <0.4 for >4 hours
- Neurological stability for >6 hours
- Haemodynamic stability without intervention for >6 hours

Safe Staffing on Ash Ward Paediatric PCCU

Nursing ratios of PCCU patients should be in continual review. National standards recommend that one nurse should provide care to two patients (1:2) who are requiring critical care intervention. If acuity is deemed higher than the current staffing ratio it is recommended that a safe staffing risk assessment should be undertaken by the Ward manager or matron in collaboration with the nurse in charge.

Safe staffing will be provided as follows:

PCCU has 3 beds staffed at a 1:2 ratio (1 x Level 2 beds and 2 x Level 1 beds) with members of the nursing team with the appropriate skill set for the acuity and complexity. Staffing requirements are assessed at multiple points throughout the shift & reported via daily safe staffing.

The NIC will not take a patient load where possible. This is to allow support from them in all areas of the ward.

Where a child requires more intense nursing intervention as assessed by the NIC, the ratio may be increased to 1:1 temporarily. Where this needs to be sustained, a discussion should be had between the NIC and the Paediatric Registrar about whether transfer to Level 3 PICU is indicated.

At least one competent PCCU nurse (including PANICC/equivalent PCCU course) should be allocated PCCU patients where possible and be aware of the PCCU patients when not allocated.

Where possible, all staff working in PCCU should have completed the PCCU induction.

Allocation of PCCU patients should be a collaboration between the NIC for oncoming shift and current shift, taking into consideration completed risk assessments, to ensure safe staffing for care needs.

Patients who require ventilation support overnight only can have altered staffing per shift as per the stability and supervision required e.g. a stable child on nocturnal BiPap only 1:4 in the day then 1:2 at night.
Children on acute CPAP can be nursed 1:2 if clinical condition allows.

Deteriorating patients should be staffed 1:1 by a nurse with PCCU competencies regardless of whether they are in the open bay or cubicle.

Parents with appropriate competencies should be supported and encouraged in the delivery of care for their child e.g., changing mask type, suctioning etc. if they wish and are present.

A child with a tracheostomy present should always have a tracheostomy competent adult with them.

A stable child may be allowed off the ward with parental supervision only providing the parents are competent and a risk assessment by the medical team has taken place.

Infection Control

Screening swabs taken at other hospitals are accepted. Discharge screening pre-transfer is not required. Routine isolation in cubicles upon transfer in from another hospital is not required.

Children with infections spread by airborne routes (e.g., measles, VZV, TB et c) will require a cubicle.

Children with known respiratory viruses should be nursed in a cubicle. Evidence of a negative respiratory viral panel is required before moving into the bay. The exception to this is cohorting of the same respiratory virus when the cubicles are already in use.

A rapid molecular test for RSV, Flu A/B and SARS CoV-2 should be taken in ED with the result known prior to moving to the ward so that children can be admitted to the appropriate area.

Power supply

Power supply to HDU bay is essential. In the event of a power supply, each patient under the PCCU umbrella should have a clinical review. If they no longer need NIV, they should be de-escalated. If they need ongoing NIV, an assessment should be made of their power supply and if they need to be moved and connected to the essential power supply in the bay (if not already there). If they are on a Trilogy EV300 these have a 12-hour battery supply. If on their home ventilator, these should run on the external battery. It is important that any child who is ventilator dependant as their baseline has two ventilators with them at all times, both connected to a power supply to charge in the event of power failure.

RESPONSIBILITIES

Registered nurse:

- Care of the PCCU patients on a 1:2 basis. They will monitor all observations and escalate where needed as condition dictates
- Administer all medication as prescribed
- Be competent in all equipment used within PCCU
- Have evidence of PCCS national nursing competencies or be working toward this.
- All documentation is completed and up to date
- Ensure that the infection control policy is adhered to

Nurse in Charge:

- Ensure all nursing documentation is completed
- Ensure nurse(s) caring for PCCU patients are competent in their role
- Support break cover of PCCU staff

- Ensure staffing for next shift is appropriate during allocation

Ward manager/PCCU Co-ordinator:

- Ensure patients are being cared for at the correct ratio
- Ensure nurses are undertaking relevant PCCU course
- Ensure National Nursing Competencies are completed
- Ensure staffing is appropriate
- Ensure risk assessments are completed where appropriate

PCCU consultant Lead:

- Responsible for oversight of service, including staffing, training, guidelines and governance
- Coordinate multidisciplinary review and learning from Paediatric PCCU case

Attending Consultant:

- To review PCCU patients daily on morning ward round
- Ensure attending consultant or the on-call consultant reviews PCCU patients in the evening
- Ensure paediatric registrar or above reviews PCCU patients at any time the nursing staff feel there has been a deterioration
- To decide and ensure when prompt escalation via STRS and/or step down to main ward is needed

Medical

Lead PCCU consultant

They will have dedicated time in their job plan for oversight of PCCU including staffing, guidelines, governance and liaising with other services. They should undertake regular clinical work in the PCC. They should develop working relationships with the network L3 hubs and tertiary respiratory teams.

Paediatric consultants

There is a dedicated paediatric consultant available 24/7 who is able to attend the hospital. There is a consultant on site 7 days a week. All consultants should participate in CPD to maintain critical care skills.

Paediatric PCCU consultants will require evidence of competency achieved through experience in specialty with CPD showing current APLS, with regular updates on training. This should include training provided by HDU Spin Competent Consultant.

Middle grade cover

A clinician trained to the equivalent of paediatric medicine and neonatal medicine ST3+ or equivalent should be available 24/7. Middle grade
(or equivalent) staff must have up-to-date advanced resuscitation training (APLS/ EPALS). They have immediate access to a consultant either in person or remotely. Appropriate training in L2 will be provided on induction and as part of an ongoing education programme including simulation.

Allied Health Professionals

Physiotherapy
There is a named paediatric lead for physiotherapy. They are responsible for ensuring physiotherapy staff have the required competence, specifically respiratory competencies. They will also support the medical and nursing staff in developing appropriate skills.

There is 24/7 access to physiotherapy with ***appropriate paediatric competencies***. Out of hours they are contactable via switchboard.

Dietician
There must be a dietician, with previous paediatric experience, to support PCCU patients during normal working hours.

Speech & Language Therapy (SALT
Access to SALT is available when required via the cross-site pathway for paediatric SALT.

Pharmacy
There must be a clinical pharmacist with previous paediatric experience available for advice. Access to the on-call pharmacist is available out of hours.

Other specialties

Anaesthetics
There is 24/7 access to onsite anaesthetics (including competencies to intubate, establish adequate vascular access and transfer) (HLP 2016). Opportunities for CPD in paediatric critical care will be provided, included but not limited to multidisciplinary simulation and STRS outreach days.

ENT
Access to ENT is via the existing paediatric pathway for ASPH (contactable via switchboard). ENT are based at RSCH our of hours. Ensure it is clearly communicated it is a "paediatric patient."

Radiology
There is 24/7 access to CXR and CT. Access to USS is provided within working hours. Access to MRI is dependent on the need for General Anaesthetic and the age/weight of child. For complex care patients, their tertiary centre would be involved to discuss the safest place.

Microbiology
Access to microbiology for advice and discussion during working hours including at weekend via switchboard.

Play Specialists
There is access to play resources at all times. Access to play specialist with relevant qualification is within working hours to provide play, distraction and mental stimulation for patients.

Level 3 PCCU/Tertiary centre advice, support and governance
South Thames Retrieval Service are the local PICU/transport team for ASPH. Advice can be sought from the outreach PICU consultant whenever necessary on 0207 188 5000. They will support L3 stabilisation and retrieval.

Education on L3 stabilisation and retrieval will be provided by STRS. Training and education in PCC will be supported by the STPN PCC education programme.

Tertiary Respiratory Teams:
Our long-term ventilation patients are under a variety of different tertiary respiratory teams and input is sought directly from the teams via the usual pathways. Locally they will be seen 6-9 monthly. Every LTV patient will have a written respiratory plan for when they are well and unwell, written by the tertiary Paediatric Respiratory team available at all times.

Clinical Resources and Guidelines
Clinical resources and guidelines relating to LTV can be found on the Pan Thames Paediatric LTV Programme website.

The LTV Hub https://ltv.services/ltv-resources-videos/ contains QR codes for medical equipment user guides and troubleshooting for all the LTV ventilators. It also has educational videos relating to LTV care.

The Pan Thames Long Term Ventilation in Children and Young People Clinical Guideline https://ltv.services/wp-content/uploads/2024/04/LTV-Clinical-Guideline.pdf is the reference document for care of CYP on LTV.

For children commencing acute CPAP:

This is available on the intranet. This is based on the Best Practice Guidance for Infant CPAP - A south London and South East of England Approach. This can be accessed https://stpn.uk/critical-care/edguidelines/cpap/best-practice-guidance/

For any critically unwell child, STRS network guidelines should be used to support and guide management. This includes drug doses and drug calculator.
These resources can be accessed online https://www.evelinalondon.nhs.uk/our-services/hospital/south-thames-retrieval-service/clinical-guidelines.aspx or via the STRS app (PICU Tools) which we encourage staff to download
As new STPN or Pan Thames network guidelines relating to LTV and PCC become available, they will be signposted to staff. These guidelines are subject to network governance and are the most up to date.

Working to network rather than trust level guidelines ensures a standard of practice across the network and that the most up to date guidelines are in use.

4.12 Data collection & Audit

Bed occupancy metrics defined as the number of occupied beds at midnight (bed occupancy days) divided by the number of funded beds will be collected. Paediatric critical care minimum dataset (PCCMDS) will be submitted to the national PICAnet audit database.

Data will also be collected on key performance indicators as determined by the PCCU Co-Ordinator, including but not limited to capacity, time spent in A&E prior to arrival on Ash Ward, transfers out.

Patient and family feedback will also be collected.

Transfers to L3 will be reviewed during the monthly paediatric morbidity and mortality meetings to share learning across the team.

Documentation

All patient documentation will be completed via Millenium. If they have a respiratory care plan, this should be made available to all staff upon presentation to ED/admission to unit.
A PCCU ward round proforma will be used to document the twice daily reviews. (PaedHDUWard)
Emergency or critical events should be documented.

Observation charts

To be documented by the nursing staff with NPEWS to help identify deterioration of these patients.
Ventilator checks should include ventilator settings, mode, pressures, oxygen requirement (L/min) tidal volume (Vte).
Humidifier checks should document whether it is off or on, temperature setting and that the water is filled.
These should be checked at the start of the shift, as part or troubleshooting and with vital signs.
Vital signs should include respiratory rate, presence of respiratory distress, oxygen saturations, heart rate, capillary refill time, blood pressure, temperature, AVPU/GCS. These should be documented minimum 4 hourly for well patients fit for discharge.
Frequency for unwell patients may be hourly or more frequent as dictated by the patient condition and escalation policy.

RISKS

PCCU patients should always remain on continuous monitoring. Alarm settings on the monitor must be checked at the beginning of each shift and adjusted to the patient's individualised needs with a check to ensure monitor alarms are high enough to be heard and responded to.

MITIGATION FOR RISKS

Escalation of alarms for monitoring, ventilation or in response to PEWS chart should be prompt. Escalation should be to the NIC and medical team.

Admissions and Exclusion criteria is set out. ENT/Tracheostomy patients with acute airway concerns are not currently included in the admission criteria due to no ENT on site at SPH.

All patients who require LTV must be able to tolerate some time off their ventilator.

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