Policy for Paediatric High Dependency Unit

The high dependency unit is a 4 bedded (2 bed, 2 cubicle) unit on Ash Ward.

Aim: To provide care to a child who requires closer observation and monitoring than is available on the ward (DOH 2001).

Principles:
- Any child requiring very frequent observations and monitoring e.g. more than hourly
- 1 nurse caring for maximum of 2 children at any one time and to stay in the HDU area
- A consultant must be informed of all admissions to HDU
- The child should be assessed at least every 2 hours by the medical team or more frequently as indicated by the P.E.W.S score
- Transfer or retrieval to PICU may be necessary and should be assessed on individual clinical condition
- Stabilisation of a sick child pre-retrieval to happen in HDU
- Children who have clinically improved to be moved to the general ward as soon as able
- 2 beds will be ring-fenced as HDU beds at all times (1 can be a cubicle) but only 1 will be blocked
- A debrief will be arranged in difficult cases, by the patient’s consultant, for all staff involved.

Staff Representatives:
- Lead consultant – Dr. Kate Irwin
- Lead Senior Nurse – Rachel Allen, Dr Nikki Sancroft
- Senior Nurses – Jenny Drummond, Jo Coombs, Natalie Asher

Indicators for admission to HDU:
- Acute asthmatics requiring IV salbutamol or who need more IV medication
- Croup requiring adrenaline nebulisers or who is clinically deteriorating
- Upper airway obstruction where tracheitis or epiglottitis is suspected and critical care necessary
- Acute bronchiolitis in high risk infants: ex-prem infants, congenital heart disease, neuromuscular disease, CF, immunodeficient patients, infants requiring 50% oxygen by headbox or suffering recurrent apnoeas (=2 significant apnoeas with colour change)
- Children requiring vapotherm or heliox
- Children with significant head injuries or those with persistent neurological symptoms / signs or a GCS <12 and where the GCS does not improve despite medical therapy or intervention – needing 15 minute neuro obs
- Status epilepticus requiring ongoing treatment
- Diabetic Ketoacidosis while still on IV insulin
- Circulatory instability due to hypovolaemia requiring frequent boluses and / or IV inotropes
- Oncology children with febrile neutropenic episodes with a) poor perfusion CRT > 4 secs, b) shock, c) toxic state, d) impending / actual organ failure
- Unstable cardiac arrhythmias requiring ongoing treatment
- Acute renal failure (urine output = 0.7ml/kg/hr) with electrolyte, ECG or BP abnormalities
- Meningococcal septicaemia (pre transfer) or stable-state meningococcaemia (with haematological or biochemical abnormalities)
- Bacterial meningitis, meningitis of undetermined cause, encephalitis only if clinically unstable or reduced GCS
- Patients following life threatening poisoning requiring IV therapy or frequent observations / monitoring including alcohol.