Sheffield Children's NHS
NHS Foundation Trust

PCCU Transition Guidelines

Reference:	1905v1
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Approved:	
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Purpose

To facilitate effective patient and family centred transition from paediatric to adult critical care services.

Intended Audience

For use by all PCCU staff members caring for young people who require transition to adult services.

Introduction

This document gives guidance on transition of care from paediatric to adult critical care.

Guideline content

1. This guideline lists the relevant health care professionals involved in supporting the transition of paediatric critical care patients to adult services. Individual professionals' responsibilities are listed in their sections.

2. The attached document **"Paediatric to Adult Critical Care Transition Pathway**" is the template used to facilitate the effective transfer of information about the child between Paediatric and Adult Intensive Care teams.

PCCU Transition - Principles

- Start at 14 years of age, if later - at least one year before date of transfer of care
- Should be patient centred: explore wishes and form plans in partnership with YP and family.
- There should be a named member(s) of staff as a point of contact and for support, for the young persona and their family.
- There should be named member(s) of staff as a point of contact, and support for the YP and family.
- Multi-disciplinary approach to transition of care.
- Early identification of MDT (medical, nursing, physiotherapy etc) in adult services.
- Agree a possible transfer of care date early in the process, review this regularly (6 monthly) to consider if a change of date is required
- MDT should consider any potential barriers, and facilitate solutions, to a smooth Transition process.
- Assess readiness for transfer of care shortly before the date of transfer with YP and family – aim to complete this during a period of stability for the young person.
- Multi-disciplinary Transition document, on eDMS, should be updated regularly (6-12 monthly).
- Adult critical care area to be identified early in the process.
- Transition Pathway document shared with adult critical care team, with time for discussion.
- Identify the members of the adult critical care team that will facilitate the transition.
- Arrange access to Transition document (eDMS) for adult critical care MDT.
- Close liaison with other sub-specialties (e.g., Neurology, Respiratory, Gastroenterology) to enable concurrent and holistic transfer of care.
- Parallel planning to develop advanced care plan with YP and Palliative Care Team.
- Regular (6-12 monthly) paediatric and adult and adult MDT meetings (medical, nursing and physiotherapy etc) with YP, and their family/cares with other health care professionals from sub-specialities as required.
- Adult Intensive Care Unit visit with adult and PCCU Transition Nurse.

- Before and after transfer of care, PCCU team to offer support with communication, decision making and advance planning for YP, families and the AICU team (as appropriate).

- Before transfer of care: final version of PCCU pathway reviewed by Young Person and their Family before being sent to adult ICU.

PCCU Transition Team Roles and Responsibilities.

Centralised Transition Team (for PCCU Patients)
•Organise and facilitate MDT meetings.
•Oversea the Transition process for each young person and their family.
•Be a point of contact for the young person and their family.

PCCU Transition Consultant
•Responsible for PCCU Transition strategy.
•Allocates consultants to patients who need the PCCU pathway.

PCCU Transition Nurse
•Identifies patents who may require a PCCU pathway.
•Writes each patient's PCCU pathway, with allocated consultant.
•Identifies appropriate adult ICU area and contacts an appropriate person to communicate with.
•Facilitates the flow of information to the adult ICU, with allocated consultant, about each patient.
•Helps to facilitate, and attend, a visit to adult area.
•Attends MDT meetings, Cross Trust Transition Meetings, Transition steering group meetings and SCH/STH PCCU transition meetings.
•Assists PCCU Transition Consultant with PCCU Transition Strategy.
•Supports the young person and family through the Transition process.

Allocated PCCU Consultant
•Explores care, prognosis and participates in Advance Care Planning with Young Person, their family and lead consultant (usually the Respiratory consultant).
•Writes PCCU pathway.
•Hands over patient to allocated adult ICU consultant.
•Attends patients MDT meetings.

ADULT SERVICES

•Discuss YP with team when referral received.

•Participate in MDT.

•Visit YP on PCCU if possible.

•Provide written information on AICU.

•Attend SCH/STH PCCU Transition meetings.

ALL LEAD MDT MEMBERS

•Fill in sections of EDMS live transition document **in partnership with YP.**

•Identify key point of contact for YP/ family.

•Liaise with colleagues from adult services.

YOUNG PERSON (and Family)

•Participate in MDT and contribute to transition document.

•Meet AICU staff in MDT.

•AICU visit.

PLAY SPECIALIST

•Commence memory book at initiation of transition: include information on social aspects, likes and dislikes.

•Highlight if reasonable adjustments needed for YP who have a learning disability, autism or hidden disability.

•Help young person (and family) to write a Hospital Passport.

PHYSIOTHERAPY

•Baseline function.

•Techniques that suit and do not suit YP.

AT TRANSFER OF CARE

•MDT: ensure live transition document up to date

•Ensure arrangements for all aspects of care are in place.

References

1. https://www.gov.uk/government/publications/send-guide-for-health-professionals. September 2014
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3. A guide to using the benchmarks for transition.2014 London South Bank University
4. Transition from children's to adults' services for young people using health or social care services. February 2016 NICE [NG43]

5. GIRFT NHS 2022 Paediatric Critical Care GIRFT programme National Speciality Report Professor Kevin Morris, Dr Peter Marc Fortune.
6. CQC June 2016 Sheffield Children's Hospital Foundation Trust Quality Report.
7. Quality Standards for the Care of Critically Ill or Injured Children. October 2021 Paediatric Critical Care Society.
8. Paediatric Critical Care and Surgery in Children Review. November 2012. NHS England and NHS Improvement.
9. Working Together to Safeguard Children Statutory Framework: legislation relevant to safeguarding and promoting the welfare of children. July 2018. HM Government.
10. Sheffield Children's Hospital Youth Forum (? date) Young Peoples Charter of Rights.
11. SEND code of practice: A Guide for health professionals. HM Government February, 2016.
12. Guidance for: Paediatric to Adult Critical Care Transition. March 2022. Paediatric Critical Care Society and Intensive Care Society.
13. NHS Long Term Plan: A Summary of Child Health Proposals. Royal College of Paediatrics and Child Health, 2019.
14. NHS Long Term Plan. NHS England, January 2019.

Name:…….. SCH Hospital Number:…….. D.O.B……
Sex:…… NHS Number: ……. Postcode: ……..

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Appendix 1

Paediatric to Adult Critical Care Transition Pathway

Name: D.O.B: Weight: (date)

Is this the weight at transfer of care Yes / No

Responsible Paediatric Clinician:

Paediatric Speciality Consultants:

Paediatric Palliative Care Consultant:

DGH Paediatrician *(include contact details):*

General Practitioner *(include contact details):*

Paediatric Critical Care:

PICU Consultant: PICU Nursing:

Physiotherapy: Home ventilation nurse:

Pharmacist: Dietician:

Psychology: Social worker:

Point of contact for young person/ family/ carers:

Adult Services:

Adult Speciality Consultants:

Adult Critical Care:

	Tertiary Centre	**District General Hospital at place of residence**
Hospital		
Transition key worker		
ICU Consultant		
Nursing		
Physiotherapy		
Pharmacist		
Dietician		

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Medical History (include baseline physiology)

Allergies: Yes / No ⍞ Details:

Safeguarding / Vulnerable adult concerns: Yes ⍞ No ⍞

Details:

Critical Care History (medical)

Airway

Own ⍞

Tracheostomy type: Size:

Grade of Intubation 1 ⍞ 2 ⍞ 3 ⍞ 4 ⍞
Comments:

Specific physiotherapy requirements

Vascular access/ other indwelling prosthetic devices

Portcath	Yes / No	Details:
Broviac/ Hickman catheter	Yes / No	Details:
CSF shunts	Yes / No	Details:
Baclofen pumps	Yes / No	Details:
Enteral feeding tubes/ devices	Yes / No	Details:
Indwelling urinary catheter	Yes / No	Details:

Other

Critical Care History (nursing)

Nutrition/ Feeding (dietician)

Include parenteral nutrition in this section

Infections

Summary of recent isolates (respiratory tract/ other)

Name:…….. SCH Hospital Number:…….. D.O.B……
Sex:…… NHS Number: ……. Postcode: ……..

Medications

Continue on last page if necessary.

Is this the final list of drugs at transfer of care: Yes / No

Relevant information relating to medicine administration:

……

……

…….....

Drug Name Strength and form	**Dose**	**Route** of administration	**Frequency** include times	**Additional information**

Name:…….. SCH Hospital Number:…….. D.O.B……
Sex:…… NHS Number: ……. Postcode: ……..

Social History

Cared for by:
(Include respite care arrangements)

Functional ability:

Communication:

Advance Planning completed jointly with young person and family/ carers

Resuscitation plans agreed: Yes / No (date……..)

Discussed with young person: Yes / No (date……..)

Discussed with Parents/ carers: Yes / No (date……..)
(write name and relationship)

CPR Yes / No

LOTA in place: Yes / No

Details of specific treatment limits previously discussed and documented:
Include young person's and family's wishes and views, and their responses.

Any other further information / issues:

Name:…….. SCH Hospital Number:…….. D.O.B……
Sex:…… NHS Number: ……. Postcode: ……..

Copy of critical care transition pathway document with patient / Carers: Yes / No ↑

Copy of critical care transition pathway document with adult critical care: Yes / No

Is this the final critical care transition document: Yes / No

Transfer of care

Handed over to Adult Critical Care Consultant (name):

Handed over by Paediatric Critical Care Consultant (name):

Copy of final critical care transition document with patient / carers: Yes / No ↑

Copy of final critical care transition document with adult critical care: Yes / No

Copy of LOTA attached: Yes / No

Signed: Print Name:

Date:

↑

Name:…….. SCH Hospital Number:…….. D.O.B……
Sex:…… NHS Number: ……. Postcode: ……..

Paediatric to Adult Critical Care Transition Checklist

Agreed date of transfer of care: ……..

Way points	Target date	Date commenced	Relevant details	Date of completion
Paediatric lead speciality transition				
Medical handover				
Nursing				
Psychology				
Physiotherapy				
Pharmacy				
Dietician				
Home ventilation				
Patient & family/ carers informed of transition				
Critical care transition MDT(s)				
“Best interests” meeting				
Adult Unit visit organised				
Adult Unit visit occurred				
Paperwork with patient / carers				
Paperwork with adult hospital				
Patient’s memory book commenced				

Name:…….. SCH Hospital Number:…….. D.O.B……
Sex:…… NHS Number: ……. Postcode: ……..

Medications

Is this the final list of drugs at transfer of care: Yes / No

Drug Name Strength and form	**Dose**	**Route** of administration	**Frequency** include times	**Additional information**

Name:…….. SCH Hospital Number:…….. D.O.B……
Sex:…… NHS Number: ……. Postcode: ……..