NHS

Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of paediatric patients during the coronavirus pandemic

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"…….and there are no more surgeons, urologists, orthopedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us".
Dr Daniele Macchine, Bergamo, Italy, 9 March 2020

As doctors, nurses and allied health professionals we all have general responsibilities in relation to coronavirus and we should seek and act on national and local guidelines. We also have a specific responsibility to ensure that essential paediatric and neonatal care continues with a minimum burden on the NHS. We should engage with those planning our local response to ensure that we are coordinated across paediatric and adult services.

We **may need to work outside our specific areas of training and expertise** to help manage the potential influx of patients. The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) have already indicated their support for this in the exceptional circumstances we may face.

Current evidence suggests that **paediatric services will not be in the frontline with coronavirus but we do have a key role to play** and this must be planned Whilst demand may be more felt in adult services, given current understanding of the virus, **paediatric services have a key role to play**. Children's hospitals, working with District General Hospitals, will need to provide a regional and national response to pressures on the NHS. The elective component of our work may be curtailed and resources diverted to areas of greater need. However, non-elective patients will continue to need high quality care and we need to ensure that they receive the care that is appropriate. We should seek the best local solutions to continue the proper management of unwell neonates and children while protecting resources for the response to coronavirus.

To this end, we will host regular webinars for Children's Hospitals and for District General Hospitals to allow sharing of information and plan service continuity.

We need to collate data and be prepared to respond to unexpected challenges and new clinical evidence, decisively and collaboratively. This is particularly pertinent with regards to the many vulnerable children and young people, including those immunocompromised, who are currently being treated and for whom there is a lack of evidence on the effects of coronavirus. It is essential that we gather data to plan for the resources children will require.

In addition, we need to protect ourselves and our workforce, and plan for the provision of emergency services at times when significant key members of staff are unavailable. This includes considering which at-risk staff should step back from the front line to protect their own health. Consideration should be given to how staff can be safely redeployed into other roles

The following principles should guide how we run our services during the outbreak:

- Follow [Public Health England guidance](#).
- Keep children out of the healthcare system, unless essential.
- Use telemedicine and other non-direct care, when appropriate.
- Plan for stopping elective procedures and treatments that may consume critical care and ward resources.
- Plan for increasing capacity for provision of oxygen and ventilators.
- Plan for admitting young adults up to 25 years of age and make contingency plans for admitting older adults.
- Comply with infection-control measures and ensure all staff have access to, and are trained in, appropriate personal protection equipment (PPE). Training should include simulation.
- Design shifts that are practical and sustainable for staff wearing full PPE.
- Use visual alerts to inform staff of symptoms on registration and reminders about respiratory hygiene and cough etiquette.
- Collaborate with hospitals and health systems on local response and to prepare for surges.
- Co-ordinate with regional and national networks of care to ensure that resources are used equitably, consistently and effectively.

The Royal College of Paediatrics and Child Health has produced valuable guidance on coronavirus in paediatric services:

- [acute paediatrics and emergency departments](#)
- [neonatal services](#)
- [paediatric intensive care services](#)
- [children with complex medical needs](#).

These pages will be updated regularly with the latest evidence and advice.

When planning your local response, please consider the following:

Leadership

- **A consultant <u>must</u> be designated as 'lead consultant' for all inpatients.** This duty can be for one day, a few days or even five days in small units. This is an essential role during crisis management. It cannot be performed by the consultant 'on-call'. They must be free of clinical duties and the role involves co-ordination of the whole service from Emergency Departments through to liaison with other specialties and managers. In larger hospitals, several leads may be required.
- It can be very stressful during a crisis. Support each other and share the workload.
- **A leadership team should support the lead and include relevant members of the multidisciplinary team.**
- Establish a daily sitrep and dashboard with critical data to share across the workforce. This should include patient flows, workforce issue, stock levels and other key messages (eg state of coronavirus response, PPE requirements).

Emergency paediatric surgical services

- Plan for the cessation of elective surgery.
- Ensure that there is 24-hour emergency theatre access with sufficient capacity, to minimise preoperative delay.
- This capacity should provide for time-critical surgical procedures in all acute surgical specialties.
- Ensure planning for early discharge.
- Use day surgery where at all possible.
- Develop rotas that allow business continuity in all acute surgical specialties. In Asia, teams were separated to reduce the risk of transmission of infection.
- Develop local policies for treatment of coronavirus-infected patients requiring surgery, to include consideration of parents attending theatre.

Service reconfiguration

- [The Paediatric Intensive Care Society and the Intensive Care Society](#) has indicated that if adult intensive care provision is at capacity, there may be a role for paediatric intensive care units in admitting young adults under 25 years of age. Providers, regions and networks should plan for admitting older adults while preparing contingency plans for admitting older patients.

- **Ventilator capacity:** Cessation of elective surgery will free ventilators and clinical areas for use should the existing paediatric intensive care unit (PICU) capacity be exceeded. Capacity will be limited by the number of ventilator-trained staff and intensivists. Trusts should explore contingencies by identifying staff who could provide additional capacity in alignment with the GMC and NMC advice. In addition, staff freed from elective commitments may be able to perform non-core intensive care functions such as communicating with relatives and vascular access procedures. Clinical staff can also be deployed in non patient-facing roles such as preparing complex intravenous infusions and medication.

- **Redeployment of staff:** Junior medical and nursing staff have significant transferable skills. Trusts should consider how services could be delivered as exclusively consultant-delivered services in the event junior paediatric staff are redirected to adult services. Similar consideration should be given to the redeployment of student and newly qualified nurses.

- **Maintenance of patient flow:** Key to the maximal use of resources will be the ability to step down care of children and young adults from PICU to wards before discharge. Trusts should make plans to ensure that these arrangements are clearly defined.

- **Safeguarding:** Trusts should ensure that duties for safeguarding are considered in the context of an influx of young adults into children's hospitals and wards. Every reasonable effort should be made to separate different age groups.