



## Irish Paediatric Acute Transport Service

### Clinical Guideline

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<b>Related Documents:</b>	
<p>The Irish Paediatric Acute Transport Service (IPATS) has produced this clinical guideline. It has been designed for nurses, doctors and ambulance staff to refer to in the emergency care of critically ill children.</p> <p>This guideline represents the views of IPATS and was produced after careful consideration of available evidence in conjunction with clinical expertise and experience. The guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient.</p>	

### Airway & Ventilation Management

- Ventilation circuit must be humidified. In children <15Kg – small (15mm) circuit must be used. ETCO<sub>2</sub> monitoring as standard
- Oral intubation in 1<sup>st</sup> instance. Cuffed ETT if high airway pressures/Head injury/Aspiration risk. See size chart.
- IPATS/PICU 'Trousers' taping as per policy available. Suction catheter sizing = 2x size of ETT (Size 4.0 ETT = size 8F catheter)

#### Normal Respiratory Compliance

- Mode is ventilator dependent. Pressure control/PS or PRVC standard modes in paediatric ventilation
- PEEP 5cmH<sub>2</sub>O
- PIP to move chest, aim Tv 6-8ml/kg/min
- Ti 0.6-0.8s (typical I:E ratio 1:2)
- RR: Neonate 30-35, infant/Child 20-30, Adolescent 15-20
- FiO<sub>2</sub>: To achieve SaO<sub>2</sub> >94%
- pCO<sub>2</sub> 4.5-6kPa
- Contact PICU if questions/difficulties arise

#### Paediatric Respiratory Distress Syndrome (Difficult oxygenation/ventilation/Poor compliance)

- Increase PEEP (7-10cmH<sub>2</sub>O)
- Aim for Tv of 5-7ml/kg/min
- Keep PIP <30cmH<sub>2</sub>O where possible
- Accept SaO<sub>2</sub> >88%
- Permissive hypercapnoea –accept pH >7.25
- Consider neuromuscular blockade / prone position
- Consider physiotherapy (if available)
- Contact PICU if questions/difficulties arise

### Cardiovascular Support

- See APLS guidelines for age appropriate HR/BP normograms
- Signs of adequate cardiac output include: Stable haemodynamics/Normal lactate/CRT<3s and U.O>1ml/kg/hr
- Fluid boluses – 10-20ml/kg aliquots of Hartmanns Solution (5-10ml/kg in trauma/head injury or cardiac illness)
- Once ≥60ml/kg fluid given or signs of fluid overload, central access (IO/CVC) and inotropic support will likely be required to complement resuscitation. Inotropics at standard strength CAN be given via peripheral line or IO if required
- Follow paediatric sepsis guidelines if shock related cardiovascular instability present & discuss with PICU
- In general: First line inotrope in cold shock = Adrenaline. First line inotrope in warm shock = Noradrenaline
- For sedation related hypotension, consider reducing sedation or changing to more cardio-stable medications before inotropic

### Sedation & Analgesia

- Standard sedation (titrate up): **Infants < 3/12:** Morphine infusion 10-30mcg/kg/hr (+/- 20mg/kg chloral hydrate q6hr PRN)  
**All others:** Morphine infusion 10-30mcg/kg/hr + Midazolam infusion 1-5mcg/kg/min
- Loading doses of each infusion (50mcg/kg) recommended before starting (if patient haemodynamically stable). This achieves a more rapid steady state. Propofol is **not** used routinely in children outside of the ambulance/theatre environment
- Muscle relaxation is **not** routine in PICU. May be beneficial in ARDS. Is frequently used during transfer to reduce risk of ETT dislodgment.

### Fluids & Nutrition

- All children require a NG tube (orogastric in head injury)
- Continuous enteral feeding preferred unless transport imminent (patients should ideally be fasted 4hr before & during transport)
- Fluid restrict all critically ill children (whether IV/Enteral) to **80%** of maintenance. 100% maintenance calculation is as follows:
  - <10Kg = 4ml/kg/hr
  - 10-20Kg = 40ml + 2ml/kg/hr for every Kg >10
  - >20Kg = 60ml + 1ml/kg/hr for every Kg >20 (max 2.5L)
- Standard IV Fluids: Infants <3/12: 0.9% NaCl + Dex 10%. >3/12: 0.9% NaCl + 5% Dex.
- Monitor blood glucose regularly and aim for a blood glucose of 4-10mmol/L. If hyperglycaemic reduce dextrose intake. Do not start insulin for hyperglycaemia in a non-diabetic child without discussion with PICU – high risk of hypoglycemia
- Keep Hb >8g/dl. If critically unwell keep >10g/dl. Minimal sampling volumes should be used to reduce iatrogenic anaemia risk

### Lines and Catheters

- Avoid urinary catheters unless muscle relaxed, shocked or in urinary retention. Please weigh nappies for accurate balances
- Arterial access is not a requirement. Can be challenging in paediatrics. USS guided approach carries high success rate. Required only if concerns for shock or respiratory distress i.e. on inotropes / FiO<sub>2</sub> >60% or difficult ventilation. Avoid brachial artery cannulation
- Indication for CVC: Inotrope infusions / multiple infusions / inadequate peripheral access. IO acceptable x24hr