A National APAGBI Survey of Time-Critical Paediatric Transfers

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Introduction and Aims

A time-critical paediatric transfer eg an acute neurosurgical emergency requires an appropriate senior anaesthetist from the referring hospital to accompany the child. The on call consultant is advised to deploy staff appropriately and a designated consultant should provide a written policy for emergency transfers of intubated children[1]. Our aim was to review current practice of time-critical paediatric transfers, the adequacy of the available senior anaesthetists, how one determines and maintains sufficient competency and if local written policies exist regarding these types of transfer.

Methods

All APAGBI Consultant anaesthetist members were invited to complete an online 10 part questionnaire via 'surveymonkey' in January-February 2016.

Results

86 responders. 50% non-specialist (DGHs, non-specialist paediatric teaching hospitals) and 50% from specialist centres.

A separate paediatric rota exists in 7% of non-specialist-responder centres and 93% specialist centres. Consultant competency is maintained (at least annually) preferentially by in house training (38%)particularly by non-specialist responders(27% v 12%) followed by APLS instructing(35%). 7% (non-specialist) and 18% (specialist) maintain competences less than annually. 13% responders (7% non-specialist, 6% specialist) noted inadequate out of hours senior cover with 6% recommending a dedicated PICU transfer resident or routine ICU assistance at tertiary centres. 6% had transfers weekly-quarterly. 21% have written policies where 10% only accept consultants and 11% also accept competent trainees.

Assessing a trainee's suitability to transfer depends on their clinical experience/competence and the patient's age/complexity (>90% responders). The presence of at least APLS was considered most important (64%)followed by (in descending order) a completed higher paediatric module (44%), transfer course(35%), intermediate module (31%) and basic module(9%).

For transfers of children aged under 3, 28% state that only consultants would be appropriate and 57% state either the completion of a higher/advanced paediatric module or a consultant would be suitable. If intubated/ventilated 14% accept consultants and 48% accept a completed higher/advanced module or consultant(37% non-tertiary v 60% tertiary).

Discussion and Conclusion

Senior paediatric cover is mostly present with a need for increased (P)ICU staff and written rotas with ad hoc availability of consultants(with paediatric interest) particularly as the sites where at least half of the inadequate cover was thought to occur had frequent (<3 month) transfers.

Senior clinical experience and competence were viewed as the most important followed by an in-date APLS and a completed higher module. RCOA[2] states that a completed higher paediatric module is required whilst GPAS[1] requires an appropriately senior anaesthetist which could include experienced non-trainee grades.

Anaesthetists are advised to maintain their skills in a team approach for resuscitation and stabilisation of the sick child[3]. Maintaining less than annual competency, particularly at non-specialist centres if the caseload and paediatric exposure is less than specialist centres, may reduce overall confidence in managing a critically ill child. This coupled with a reduced threshold of trainee level (intermediate v higher) deemed acceptable to transfer intubated/ventilated children may require increased vigilance.

References

1. Wilkinson K A, Brennan L J, Rollin A-M. Guidelines for provision of anaesthetic services -Paediatrics 2016.
2. Higher Syllabus, Paediatrics. RCOA 2012.
3. Standards for Care of Critically Ill Children 5th edition. PICS, London 2015.