

Guidance for Admission Decisions:

**Supporting the Placement of Young
People in the most appropriate
Critical Care unit**

Classification: General

Organisation	Guidance for Admission Decisions: Supporting the Placement of Young People in the most appropriate Critical Care unit
Document Purpose	Guidance
Title	Guidance for Admission Decisions: Supporting the Placement of Young People in the most appropriate Critical Care unit
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Description	To support decisions on where best to provide care for young people (YP) aged 16-18 years who require Intensive Care Support.
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Purpose

This guideline is to assist East Midlands Adult Critical Care, Paediatric Critical Care, Emergency Department, Anaesthetic, Paediatric and Adult clinicians to make decisions on where best to provide care for young people (YP) aged 16-18 years who require Intensive Care Support.

This guideline outlines the rationale for which young people should have care and treatment delivered in an Adult Intensive Care Unit (AICU) and which young people will have care and treatment on a Paediatric intensive Care Unit (PICU).

Aim of the Guideline

This guideline aims to offer a clear framework to guide these sometimes complex decisions, but also recognises that each of our patients deserve consideration as an individual. In keeping with national guidance transition between adult and paediatric critical care should follow transition by other specialties. However, this guide recognises that geography, capacity, acute pathology, and wider needs of a patient and their family may also factor into these decisions.

This guide relates to “business as usual” and recognises that a different approach maybe needed at times of surge where mutual aid is required to support critical care services who have exhausted their capacity.

Definitions used in this document

A child: Under the age of 16

A young person: between the ages of 16 and 18¹ An adult: Over the age of 18

The patient’s weight and developmental status are usually not a primary factor in this decision but may need some thoughts around equipment, general environment, exposure to other patients and accommodation for family.

When does Transition occur?

Transitioning care of chronic or longer term conditions from paediatric to adult services is a process that should begin around the age of 13 with the aim of ensuring the child or young person is well prepared for the move to adult services at an appropriate time, usually aged 16 or 17.

Transition processes are still evolving, with the aim of delivering an individualised, timely, supportive, collaborative and efficient multi-speciality process. The complexity of an individual patient, including their social and/or educational needs, their life expectancy or difficulties finding appropriate adult services, as well as a host of other factors may all contribute to delays or

difficulties in transition, which may impact on which admission pathway a patient is best suited to when they present acutely.¹

It is well recognised within a number of national guidelines that transition during an acute admission, or a period of instability at home (including potentially imminent end of life) is very rarely in the young persons best interests, and should be avoided unless there are clear benefits to this approach.

It is also useful to recognise that ward and critical care colleagues can, in the right circumstances, work collaboratively across adult and paediatric areas to support optimal patient care and their colleagues.

Principles of the guideline

Patient centred discussions should be held at all times. There will be circumstances where it is right for the patient to go to a unit which is not the first option as per this guideline. Clinicians are encouraged to remember that the best interests of the patient, whatever their age, must always be paramount.

This guideline applies under “normal circumstances”. Extraordinary surges in critical care demand, whether Adult or Paediatric, should trigger cross-critical care mutual aid in accordance with pre-agreed unit and regional surge plans. At this point age boundaries may become more flexible. Careful case by case consideration and cross unit/speciality working and support is essential.

¹ Legally anyone under 18 years of age is considered a child and a number of legal processes, safeguarding, risk management and other considerations approach 16 and 17 year olds the same as younger children.

Patient is in a Trust with both a PCCU and an ACCU

ACC = Adult Critical Care PCC = Paediatric Critical Care

Note these are starting points. Sensible discussions are expected on a case-by-case basis

<16y	16-18y				>18y
	Capacity		Known Patient Transition		
	PCC	ACC	Complete	Not Complete	
↓ PCC	Yes	Yes	ACC	PCC	Choice [^]
	Yes	No	PCC*	PCC	PCC
					↓ ACC

Notes

*In these situations the patient should be transferred back to their expected unit as soon as possible

[†]For patients where paediatric care would be appropriate

[^]Choice should be offered only when clinically appropriate, and not where either option would be detrimental to the patient or deemed not in the patient's clinical best interests.

If there is no capacity in either unit, it is the responsibility of the stated specialist or critical care team to care for the patient.

Scenarios:

The child is under the age of 16:

They are admitted to Paediatric Critical Care, whatever their pathology (with the possible exception of obstetric critical illness where local guidelines should be followed). Specialist input from adult clinicians is welcome.

There may be exceptional circumstances where children under 16 are best managed on adult units. These may include (but are not limited to) specialist maternal critical care input and ECMO support. This must be agreed by both AICU, PICU and the child's parent or guardian.

The young person is aged 16 or 17

If there is capacity in the relevant unit:

- If there are no ongoing health issues under follow up at hospital, a decision based on their pathology, development, and where relevant taking into account patient choice or patient's best interests (if capacity is lacking), should be reached.

- If the patient is known to paediatric services for an ongoing issue which is directly relevant to the admission, then they should go to Paediatric Critical Care.
- If the patient is known to adult services for an ongoing issue relevant to the admission, then they should go to Adult Critical Care.

If there is no capacity in the relevant unit:

- The other local critical care should admit the patient, with support from the critical care team within the preferred unit. They should be transferred back to the more preferred unit at the first opportunity. The relevant specialists should support the patient's care whichever critical care unit they are on.

If there is no capacity in either unit:

- ACC and PCC teams should discuss potential capacity solutions, including mutual aid, to agree a safe and appropriate admission route. Where there is a preference to admit the patient to a specific unit as described above then this team will take the lead in finding a solution.
- Discharge should be back to the specialist ward, if applicable, for their pathology. This may be from PCC to adult ward or vice versa when the choice of critical care unit was based on capacity, but this is not the right time to transition from paediatric to adult care.

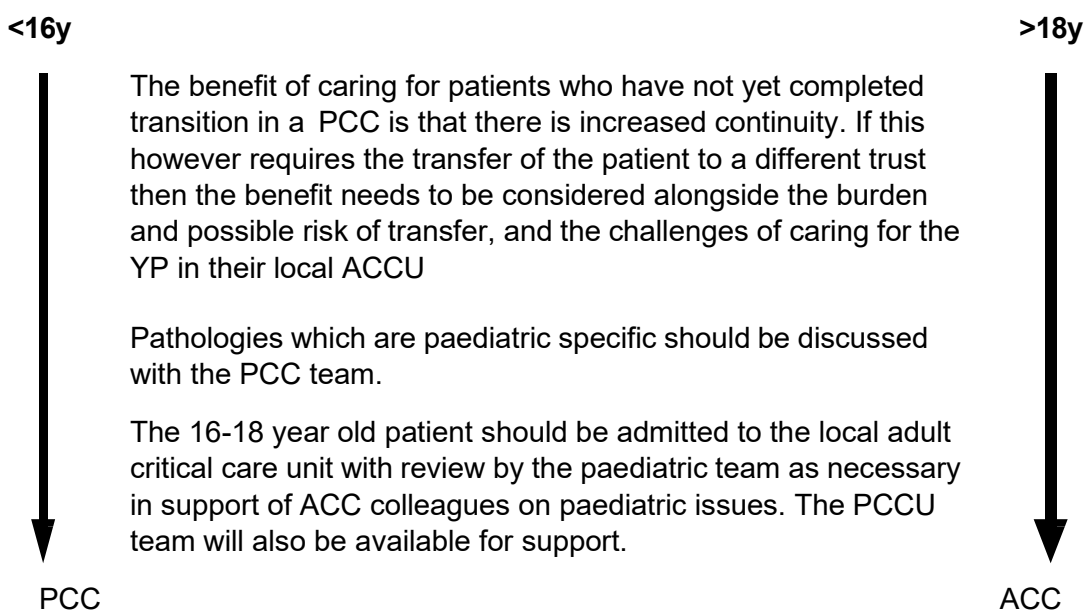
The adult is aged 18 or over:

- They are admitted to Adult Critical Care. Rare exceptions of complex patients who are yet to transition and present with an acute condition relevant to their ongoing paediatric follow up may require specific discussion, especially if they are well known to PCC or might be approaching EoL.

Patient is in a Trust with an ACCU but no PCCU

ACC = Adult Critical Care PCC = Paediatric Critical Care

Note these are starting points. Sensible discussions are expected on a case-by-case basis



The child is under the age of 16:

- They are transferred to Paediatric Critical Care, whatever their pathology.

The young person is aged 16 or 17 and is under follow up with the local paediatric team.

- The patient should be admitted to the local adult intensive care unit. The benefit of caring for patients who have not yet completed transition in a PCC is that there is increased continuity but in that situation continuity is probably better preserved in the local hospital.
- And is under follow up with paediatric teams at a hospital with a PCCU. The patient should be discussed with the local PCCU via CoMET to consider transfer to local PCCU, especially when the acute presentation relates to the ongoing care provided in the same trust.
- And is not known to a paediatric team. The patient should be admitted to the local adult intensive care unit. The risks of transport would typically outweigh any potential benefit gained by moving to a paediatric intensive care unit. Advice from PCCU can be accessed via CoMET if needed.
- And needs or might need specialist care not available at the local hospital, including paediatric specific pathology. The patient should be discussed with the local Paediatric

Critical Care Unit via the CoMET team, to discuss whether there would be material benefit in transferring the patient. Specialist teams and/or adult critical care colleagues could be included in this discussion.

- Similar considerations to those described for a patient in a hospital with both ACCU and PCCU should be applied in these situations.
- The adult is 18 years old or older. The patient should be admitted to the adult critical care unit. Rare exceptions of complex patients who are yet to transition from regional services and presents with an acute condition relevant to their ongoing paediatric follow up may require specific discussion, especially if they are well know to PCC or might be approaching EoL. The local PCC consultant can be contacted via CoMET.

Safeguarding considerations

When a young person under the age of 18 is admitted to an adult critical care unit, every effort must be made to safeguard them from exposure to potentially distressing sights and sounds within the adult environment. Ideally, they should be accommodated in a side room to provide a degree of separation and protection. Where this is not feasible, appropriate measures must be taken to minimise exposure and mitigate the risk of psychological harm. If there are adult patients within the unit who are known to pose a risk to children, admission of the young person to that area may be deemed inappropriate. These considerations should form a part of the decision-making process.