tools, they are inappropriate for PICUs. We devised an Agreed Limitation of Treatment Form (ALT) for professionals caring for children for whom a decision has been made to withdraw or withhold life-sustaining treatment. We have been using it for 5 years. Recent changes to national guidance have prompted us to review our practice.

**Aims** To evaluate our Limitation of Treatment process by reviewing our current practice, comparing it to professional guidance and to practice in other PICUs.

**Method** We compared children for whom an ALT had been completed to children who died without an ALT.

We reviewed each ALT form and the entries in the medical notes.

We obtained the opinions of staff on our PICU.

We reviewed practice in our PICU against the recent changes to professional guidance from the Royal College of Paediatrics and Child Health and the General Medical Council.

We surveyed practice in other units.

**Results** There were pre-existing severe or life-limiting conditions in 85% of patients with an ALT compared with 46% of those who died without an ALT. 13 out of 16 ALT forms were either not fully completed or not consistent with entries in patient notes.

Nursing and medical staff found the form to be useful as a communication tool but requested some changes to the wording and layout of the form.

Our practice is in line with National Guidance.

There is no uniformity among the different PICUs and only a few use forms.

**Conclusion** We found the Limitation of Treatment forms very useful and consistent with the professional guidance but the quality of documentation needed to be improved. We have made changes to our practice and would suggest that a similar document would be beneficial for all PICUs.

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**Children with Life-Limiting or Complex Chronic Conditions in PICU: Prevalence, Within PICU and Long Term Outcomes**

**Aims** This study aimed to review the literature to ascertain what proportion of admission to PICUs are for children with Life Limiting Conditions (LLC) or Complex Chronic Conditions (CCC) and what are their within PICU and post PICU outcomes.

**Methods** A systematic review of the literature was undertaken with electronic databases, MEDLINE and Embase searched for studies published in English between 1990 until Aug 2014. Hand searching of reference lists was also undertaken.

The titles and abstracts of all the retrieved papers were reviewed for inclusion by two authors. Data was extracted from the full-texts of all the studies which fitted the eligibility criteria. A narrative synthesis of the included studies was undertaken as the heterogeneity of definitions and therefore the included populations and outcomes did not allow for a meta-analysis to be undertaken.

**Results** The database search retrieved 9439 references. 83 full texts were screened for inclusion and 19 papers were included in the data extraction and synthesis process.

A large US study found the prevalence of children with CCC in PICU to be 53% (range 22.4–70.6%). The smaller study from Greece found a prevalence of 37.8% and a multi-country study found a prevalence of 67%.

The within PICU mortality rates were highest for the haematopoietic stem cell transplant (HSCT) patients (45–69%) with the studies on oncology patients alone having mortality rates of 16–27%.

Four of the studies presenting post PICU mortality data were for patients admitted to PICU post HSCT (mortality rate ranged from 67–85%), three were on oncology patients (mortality ranged from 17–48%) and one was children with severe neurological impairment requiring mechanical ventilation (50% mortality one year post PICU).

**Conclusions** Children with CCC formed a large but variable proportion of PICU admissions in the US and had higher within PICU mortality. Children admitted to PICU post HSCT had very high within and post PICU mortality rates.

There were no studies undertaken in the UK and none using the LLC definition to define their population of interest. There were no large studies which assessed long term mortality or outcome after PICU.