HAUTE AUTORITÉ DE SANTÉ

RECOMMENDING
BEST PRACTICES

RECOMMENDATION

Diagnosis and management of Children with Post-Intensive Care Syndrome in Paediatrics (PICS-p)

Adopted by the HAS Board on 10 July 2025

Clinical practice guidelines (CPGs) are defined in the health field as systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.

CPGs are rigorous summaries of the state-of-the-art and scientific data at a given time, described in the evidence report. They do not exempt healthcare professionals from exercising discretion in the patient's treatment; this must be the treatment considered to be most appropriate on the basis of their own findings and the patient's preferences.

These clinical practice guidelines were developed according to the method summarised in the evidence report and in the HAS methodological guide available online: Development of best practice guidelines – Clinical practice guidelines method.

The objectives of this guideline, the population and the professionals concerned by its implementation are summarised in the description of the publication and described in detail in the evidence report.

The latter and the guideline summary can be downloaded from www.has-sante.fr.

Grades of recommendations

A	**Established scientific evidence** Based on studies with a high level of evidence (level of evidence 1): randomised controlled trials with high power and without major bias or meta-analysis of randomised controlled trials, decision analysis based on well conducted studies.
B	**Scientific presumption** Based on scientific presumption provided by studies with an intermediate level of evidence (level of evidence 2) such as low power randomised controlled trials, well conducted non-randomised controlled studies, cohort studies.
C	**Low level of evidence** Based on studies with a lower level of evidence such as case-control studies (level of evidence 3), retrospective studies, case-series studies, comparative studies with major biases (level of evidence 4).
EC	**Expert consensus** In the absence of studies, the recommendations are based on agreement between experts in the working group after consultation of the review group. The absence of grading does not mean that the recommendations are not relevant and useful. However, it should prompt additional studies.

Description of the publication

Title	Diagnosis and management of Children with Post-Intensive Care Syndrome in Paediatrics (PICS-p)
Working method	Memo sheet
Objective(s)	Development of a guideline for healthcare professionals, with the aim of improving the prevention of post-intensive care syndrome (PICS-p) and the management of pediatric patients with PICS-p in terms of the following: – definition of patients at risk of PICS-p; – diagnosis of these patients; – early and long-term management of PICS-p; – care pathways. Production of a document intended for patients and their families or carers to alert them on this PICS-p and support them in its management by referring them to healthcare professionals trained in this syndrome.
Targets concerned	These recommendations concern all pediatric patients admitted to an intensive care unit in whom PICS-p is suspected or diagnosed, and any patient following a hospital stay in an intensive care unit. They are intended for all healthcare professionals who treat or are likely to treat children with PICS, including: general practitioners, physical and rehabilitation physicians, internal medicine specialists, respirologists, intensive care physicians, psychiatrists, neurologists, school doctors, ENT specialists, infectious disease specialists, follow-on care and rehabilitation physicians, skin and cosmetic surgeons, clinical psychologists, speech therapists, nurses, physiotherapists and occupational therapists.
Requester	Direction générale de l'offre de soins (French Directorate General of Health Care Provision)
Sponsor(s)	Haute Autorité de santé (French National Authority for Health – HAS)
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Literature search	See documentary search strategy described in Annex 2 of the evidence report Performed by Ms Sophie Despeyroux, assisted by Ms Sylvie Lascols (Head of Documentation-Monitoring Department: Ms Frédérique Pagès)
Authors	Authors of evidence report: – Dr Judith Chareyre, Project Officer, Bordeaux – Dr Marie Pouletty, Project Officer, Paris With the participation of the working group chaired by Dr Michaël Levy (see list at the end of the document)
Declaration of interests	The members of the working group have submitted their public declarations of interest to the HAS. They are available to view on the https://dpi.sante.gouv.fr website. They were reviewed according to the analysis grid of the HAS guidelines for the declaration of interests and management of conflicts of interest. In its analysis, the HAS also included the "Transparence-Santé" database, which requires manufacturers in the healthcare sector to publish the agreements, remuneration and benefits that bind them to players in the healthcare sector. The interests declared by the members of the

	working group and the information included in the "Transparence-Santé" database were deemed to be compatible with the participation of the experts in the working group.
Validation	Version dated: 10 July 2025
Updating	
Other formats	Rationale, toolkit guide for the primary care practitioner

This document and its bibliographic reference are available to download at www.has-sante.fr

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Contents

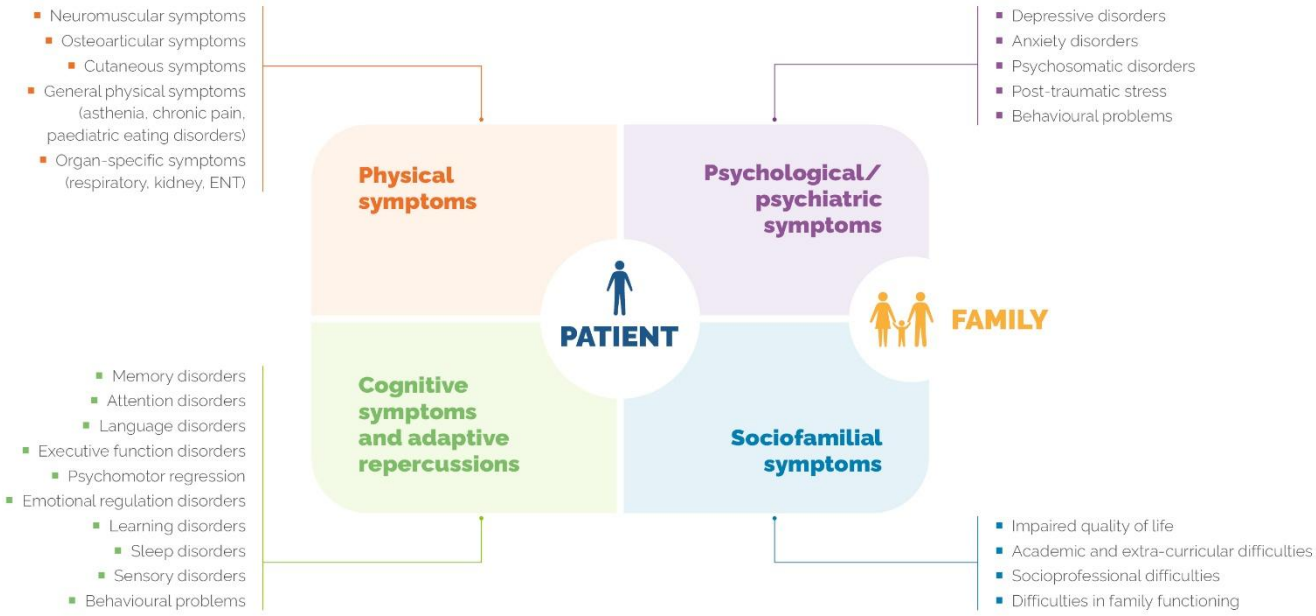
1. What is PICS-p?

Post-intensive care syndrome in paediatrics (PICS-p) is a prevalent condition characterized by new or worsening impairments in physical, cognitive, psychological/psychiatric, and/or social–familial functioning that develop following admission to a paediatric intensive care unit (PICU). These impairments may restrict daily activities, diminish the quality of life of affected children and their families, and disrupt family organization and dynamics.

Symptoms may manifest in the child, parents, siblings, or the extended family network.

The concept of "PICS-family," previously described in adult populations, is therefore incorporated into the PICS-p framework as a fourth domain.

Diagram 1 Definition of PICS



1.1. What are the problems associated with this syndrome?

The diagnosis of PICS-p should be considered when one or more of the following symptoms appear, worsen or persist after a hospitalisation in the pediatric intensive care unit. These symptoms can appear weeks, months or years after the hospitalisation:

- physical symptoms related to general disorders (asthenia, chronic pain, paediatric eating disorders), neuromuscular disorders, osteoarticular disorders, skin disorders and/or more specific organ disorders (respiratory, renal, ENT or ear-nose-throat) (EC);
- cognitive symptoms (memory disorders, language disorders, attention/executive function disorders, comprehension disorders, emotional regulation disorders) and their adaptive repercussions (learning disorders, behavioural disorders, interpersonal relationship disorders, etc.) (EC);
- psychological/psychiatric symptoms for the child and their family (anxiety disorders, depressive disorders, post-traumatic stress, psychosomatic disorders, etc.) (EC);

- sociofamilial symptoms:
  - in the child: deterioration in quality of life, difficulty returning to school extending to anxiety-based school refusal or difficulties in the extra-curricular environment,
  - in the family: deterioration in the quality of family life or family functioning (parents and siblings), repercussions on the parents' professional activity, social isolation.

These symptoms, particularly when they are multiple, may have significant impacts on the quality of life of patients and their families, their psychomotor development, their autonomy and on the ability to return to school, for children, and to work, for parents.

Sociofamilial symptoms may have a direct negative impact on the child's future and quality of life.

Finally, unlike adults, the recovery trajectories of children, who are in continuous development, are more heterogeneous. As a consequence, certain symptoms may not appear or be detected until several years after PICU discharge (after any other underlying cause has been ruled out).

1.2. What are the risks of patients developing this type of syndrome?

PICS-p can occur in all children hospitalized in the PICU. However, patients with one or more of the following risk factors should be considered at high risk of developing PICS-p (EC).

Table 1. Risk factors

Pre-admission	Related to the stay and intensive care	After discharge
– Young age (< 1 year old) – Chronic and/or congenital disease – Psychological/psychiatric manifestations or previous trauma in children and their families (EC) – Low socioeconomic level – Quality of the family/emotional environment (EC)	– Unscheduled admission – High severity score (PIM or PRISM score, PELOD 2, pSOFA) – Reason for admission: sepsis/septic shock, cardiorespiratory arrest, ARDS, head trauma, meningoencephalitis – Hospital stay ≥ 3 days – Prolonged mechanical ventilation ≥ 3 days – Organ support: extra-renal purification, ECMO, inotropic or vasopressor support – Repeated invasive procedures – Prolonged sedation (benzodiazepines and opioids) – Delirium/confusion, withdrawal syndrome – No parent or close relative at the patient's bedside (EC) – Lack of psychological support for children and their families – Lack of treatment by a multidisciplinary rehabilitation team	– Psychological problems in parents secondary to the stay – Lack of medical and/or paramedical follow-up

To date, no reliable tool for predicting PICS-p at an individual level can be recommended. This underscores the importance of actively and repeatedly screening for this syndrome in any patient who has been hospitalised in a PICU, especially when one or more risk factors are present (EC).

2. How can we prevent the subsequent onset of post-intensive care syndrome in paediatrics?

Practitioners in PICUs are advised to follow the ABCDEFGH bundles of good practice (A “Attention to Analgesia; Avoid oversedation; allow Awakening”, B “spontaneous Breathing trials", C ″Choice of sedation and analgesia", D "Delirium prevention, surveillance, and management", E "Early mobilisation and Exercise", F "Family engagement and empowerment"), G ″Good nutrition", H ″Humanism" (EC).

2.1. Prevention of physical symptoms

It is recommended that protocols be implemented for positioning, comfort, nursing and early mobilisation, encompassing passive and active mobilisation and out-of-bed care activities (e.g. physical activity, holding infants in arms, and seating older children in chairs) (EC).

This rehabilitation can be summarised in four points (grade C):

1. It is recommended that mobilisation be assessed at an early stage, ideally within 24-72 hours of admission to the PICU.
2. It is recommended that mobilisation be individualised and performed at least once daily: taking into account the child’s age, neurological and psychomotor development, and underlying pathology, in accordance with the concept of paediatric “functional mobility.”
3. It is recommended that mobilisation be carried out safely, appropriately and adapted to the patient’s clinical condition.
4. It is recommended that mobilisation be coordinated by a multidisciplinary team—including physicians, physiotherapists, speech therapists, educators, psychomotor therapists, occupational therapists, nurses, and care assistants—with the involvement of the patient’s parents or caregivers wherever possible

2.2. Prevention of cognitive symptoms

Optimisation of analgesia and sedation in the PICU, through regular daily reassessments, is a key component in the prevention of cognitive symptoms of PICS-p (EC).

It is based on:

- regular assessments of comfort using appropriate sedation and pain scales (e.g. the COMFORT-B sedation scale with clearly defined therapeutic objectives for sedated, mechanically ventilated patients, Grade B);
- screening for withdrawal syndrome after 3 to 5 days of sedation/analgesia using appropriate scales such as the Withdrawal Assessment Tool (WAT-1) or the Sophia Observation Scale (SOS weaning part) (Grade C);
- prevention and treatment of withdrawal syndrome through the use of sedation protocols (search for the minimum effective dose, regular reassessment of the level of sedation and reduction/early cessation depending on the clinical condition) (Grade C).

Multimodal management of delirium is also recommended and should include (Grade B):

- early detection, beginning 24 hours after admission, and on a regular basis, using validated and age-appropriate assessment tools *(*Cornell Assessment of Pediatric Delirium (CAPD), SOS PD (SOS delirium section);
- prevention and treatment using non-pharmacological strategies, as well as sedation-analgesia protocols designed to minimize benzodiazepine use, with active involvement of parents in the care process.

2.3. Prevention of psychological/psychiatric symptoms

Prevention of psychological/psychiatric symptoms in children is closely intertwined with the prevention of similar symptoms in their parents, focusing on three key elements: communication, care environment, and psychosocial support.

Communication

Regular communication with patients, regardless of their age or developmental stage, and with their parents is recommended:

- through formalised medical interviews, facilitated by a key intermediary (e.g., the referring physician) (EC);
- on a daily basis, at the patient's bedside, including when the patient is sedated (EC);
- using communication methods tailored to the child's age, developmental level, and communication abilities (Grade B).

Environment

It is recommended to pay attention to the patient's environment and sensory well-being including factors such as noise, lighting, facilities, parental involvement in care (EC).

Psychosocial support

It is recommended to implement interventions aimed at reducing anxiety in patients and their relatives during and after hospitalisation in PICU (Grade B).

It is recommended that the organisation of PICUs, both geographically and functionally, allow parents to be present with their child 24 hours a day, 7 days a week (Grade B).

The presence of parents, their substitutes, or other support arrangements (e.g., mentoring programs, associations, or relatives) should be encouraged to minimise the amount of time the child is left alone (EC).

Regular psychological support should be provided to patients and their parents, beginning with an early preventive consultation with a psychologist dedicated to the PICU, and, if necessary, a child psychiatrist. Patients at highest risk should undergo targeted screening to prevent the development of post-traumatic stress disorder (Grade B).

It is recommended to facilitate visits by siblings, which can be beneficial not only for the patient, but also for the siblings and their families. The initial visit should be carefully prepared in advance, with siblings accompanied, ideally, by a psychologist (EC).

2.4. Prevention of sociofamilial symptoms

Prevention of symptoms in family and relatives is closely interconnected with the prevention of symptoms in children.

It is recommended that the relatives of hospitalised children receive particular attention. The organisation of PICUs should enable parents to remain with their child 24 hours a day, 7 days a week. Parents should also be allowed to be present during intensive care procedures (including cardiopulmonary resuscitation, intubation and catheter insertion) when appropriate to the clinical context and accompanied by a dedicated professional (Grade C). They should furthermore be involved as fully as possible in their child's care (Grade C).

It is recommended that parents be offered early and regular psychological support during hospitalisation and afterwards (Grade C).

It is recommended that the need for social work support be assessed for all families, regardless of socioeconomic status, in order to facilitate access to available resources and assist parents during and after hospitalisation in the PICU (EC).

Appropriate, timely and repeated communication regarding their child's clinical condition is an essential component in preventing post-traumatic stress among parents (Grade C).

3. How can post intensive care syndrome in paediatrics be screened for and diagnosed during hospitalisation and in community healthcare settings?

Screening for PICS-p in patients and their families involves all healthcare professionals who may encounter the patient during the year following admission to PICU (EC).

It is recommended that patients and their families be routinely offered a structured clinical assessment, repeated over time, to detect the development of PICS-p symptoms (EC).

This assessment should be performed (EC):

- before discharge from the PICU (for the earliest symptoms);
- at key transitional periods in the patient's care pathway: discharge from the PICU to conventional hospitalisation wards and before hospital discharge;
- within three months of discharge;
- ideally, under the coordination of the PICU.

Clinical history and physical examination alone may suggest the presence of PICS-p. It is recommended that symptoms be actively sought in children and their families (Figure 1. Toolkit guide for primary care practitioners).

No individual symptom is pathognomonic for PICS-p. However, persistent symptoms, or those that significantly affect the daily life of the child or their family, should be seen as warning signs that may indicate PICS-p (EC).

In addition to clinical history and physical examination, validated scores and assessment scales can be used to screen for PICS-p. An evaluation should be performed systematically prior to discharge from the PICU and repeated throughout the patient's course of care. The selection of specific tests should be tailored to the patient's clinical condition (EC).

Table 2. Non-exhaustive proposal of scales for PICS-p screening according to symptoms and age

Symptom of PICS-p	Examples of available tools	Tools for use in community medicine
Physical	Multimodal scales: Pediatric Overall Performance Category (POPC) scale: used for measuring overall performance and functioning Screening scales for neuromotor disorders: Six-Minute Walk test: to measure the "functional" ability to walk a long distance for 6 minutes Timed Up & Go (TUG) test: timed test of the ability to get up from a chair Screening scales for specific organ disorders:	TUG pVHI

	pVHi (dysphonia)	
Cognitive	Pediatric Cerebral Performance Category (PCPC) scale: used for measuring overall cognitive capacity	PCPC
Psychological/psychiatric	Paediatric scales: Young Child PTSD Checklist (YCPC): screening scale for post-traumatic stress (1 to 6 years) Child Revised Impact of Event Scale (CRIES): screening scale for post-traumatic stress (> 8 years) Hospital Anxiety and Depression Scale (HADS): screening test for anxiety and depressive symptoms (> 13 years)	For the child: YCPC (1 to 6 years) CRIES (> 8 years) HADS (> 13 years)
Sociofamilial	– Paediatric scales: Measurement of functional independence for children (Wee FIM) Pediatric Symptom Checklist (PSC): psychosocial functioning scale – Adult scales for use with parents: Post-Traumatic Stress Checklist (PCL-5): screening scale for post-traumatic stress in adults Patient Health Questionnaire-8 (PHQ-8): depressive symptoms Generalized Anxiety Disorder-7 (GAD 7): anxiety symptoms	For children: – Wee FIM (> 6 months) – PSC (> 4 years) For parents: GAD 2 (short version) PHQ-2 (short version) PCL-5
Multimodal scales	Strength and Difficulties Questionnaire (SDQ): scale of mental health and social, emotional and behavioural functioning Child Behaviour Checklist (CBCL): child behaviour scale providing a standardised description of emotional and behavioural problems, as well as academic and social skills	SDQ (3 to 6 years) CBCL (6-18 years)

Each of the scales can be used in community healthcare settings within 5 to 10 minutes. They are easily accessible and free (see Appendix for the full set of scales in the evidence report).

Although not validated in PICS-p screening, the MRC scale, the 6-minutes' walk test, and the TUG can be used to identify patients who require referral for specialist follow-up if abnormalities are detected.

4. What information (including telehealth) should be communicated to the child's healthcare professionals?

Upon PICU discharge, it is recommended that parents be provided with a letter systematically addressed to the child's attending physician (general practitioner and/or paediatrician) and relevant specialists. Depending on the circumstances, parents will be encouraged to share this letter with other relevant healthcare professionals, such as the childcare centre physician, maternal and child welfare physician, school doctor or any other provider involved in the child's care (EC).

It is recommended to ensure effective communication throughout the care pathway by systematically including the following information in the discharge letters (EC):

- the potential risk of developing PICS-p and the reassessment procedures;
- a summary of the clinical status and observations at the time of discharge;
- the referring healthcare professional during the stay in the PICU or the healthcare professional in charge of the post PICU follow-up consultations;
- recommendations for patient-specific post-PICU follow-up, including specialist consultations, rehabilitation, and other relevant interventions.

It is recommended that, based on the child's age, both parents and patients should be made aware of the range of symptoms that could indicate PICS-p during or following a PICU admission, and be encouraged to seek medical advice if necessary (EC).

It is recommended that parents be encouraged to schedule a routine appointment with the child's general practitioner (either face-to-face or via teleconsultation), within one month of hospital discharge, regardless of the child's risk of developing PICS-p (EC).

5. How should patients with post-intensive care syndrome in paediatrics be managed?

It is recommended that patients with PICS-p receive follow-up care from a multidisciplinary team (EC).

To this end, it is advisable to:

- establish and coordinate healthcare services and follow-up care after discharge;
- identify an appropriate care program, such as coordinated outpatient follow-up with a general practitioner or rehabilitation centre if needed; or dedicated post-PICU consultations in hospital within three to six months of the patient's discharge;
- Arrange for the child's reintegration into school to be optimally supported through a personalised management plan (projet d'accueil individualisé – PAI) validated with the family and school doctor (EC);
- facilitate referrals to the Departmental House for Disabled Persons (*maison départementale pour les personnes handicapées* – MDPH), when appropriate (EC).

It is recommended that a designated hospital healthcare professional with expertise in PICS-p and a comprehensive understanding of the patient's clinical background and PICU care should commence this monitoring.

The intention is to subsequently transfer the coordination of ongoing care to the patient's general practitioner (EC).

The aim of this management strategy is to restore family, social and school dynamics, while improving the quality of life of both the child and their family (EC).

For the attention of paediatric critical care teams

It is recommended to appoint a designated medical contact for the patient, who can be easily accessed by other healthcare professionals (EC).

It is recommended that the families of PICU patients be informed about PICS-p through multiple channels, including a pre-discharge interview, informational posters, booklets, and discharge letters (EC).

It is recommended to appoint a trained PICS-p advisor within the PICU whose role is to raise awareness, provide staff training, and ensure adherence to best practices in paediatric resuscitation (ABCDEFGH) (EC).

Participants

The following professional bodies and patient and user associations were consulted to propose experts invited individually to take part in working/review groups:

French board of physiotherapists (CMK)*

French board of general medicine (CMG)*

French national board of psychiatry (CNPP)

French national council for infectious diseases professionals – French Infectious Diseases Federation (CNP-FFI)*

French national council for anaesthesia and intensive care and perioperative medicine professionals (CNP-ARMPO)*

French national council for occupational therapy professionals*

French national council for infectious and tropical diseases professionals (CNP-MIT)*

French national council for internal medicine professionals*

French national council for physical medicine and rehabilitation professionals (CNP-MPR)*

French national council for neurology professionals*

French national council for respiratory medicine professionals (CNPP)*

French national council for speech therapy professionals

French national council for nursing professionals (CNPI)*

French national council for intensive care and resuscitation professionals (CNP-MIR)*

French national council for ENT and cervicofacial surgery professionals (CNP-ORL)*

French respiratory medicine federation (FFP)*

French psychiatry federation

French federation of psychologists and psychology (FFPP)*

French national federation of user associations in the field of psychiatry (Fnapsy)

France Assos Santé

French physical medicine and rehabilitation society (Sofmer)

French-language society for infectious diseases (Spilf)

French national union of families and friends of patients with mental illnesses or disabilities (UNAFAM)

French national union for the development of research and assessment in speech therapy (Unadreo)*

(*) This body proposed one or more experts for this project.

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