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Operational policy for Paediatric Bed Management including Full Capacity management and Nurse Staffing Escalation

Key Document code:	WAHT-TP- 083	
Key Documents Owner:	Dana Picken	Matron
Approved by:	Paediatric Quality Improvement meeting	
Date of Approval:	9th February 2024	
Date of review: **This is the most current version and should be used until a revised document is in place**	9th February 2027	

Key Amendments

Date	Amendment	Approved by
12/09/2018	The Operational policy for Paediatric Bed Management including Full Capacity management and Nurse Staffing Escalation will replace the Paediatric inpatient full capacity protocol (WAHT -TP - 055) and Bed Management for Childrens wards WAHT -TP-083)	Paediatric QIM
15th Jan 2020	Minor amendment to introduction. Addition of Unexpected/Adverse events within children clinics Flow chart added to appendix 6	Paediatric QIM
26th March 2021	Approved with no amendments	Paediatric QIM
9th Feb 24	Close ward amended to suspend admissions	Paediatric Guideline Review Day
	Safer Nursing Care Tool	
	Planned nurse staff numbers for Riverbank amended to 7RN at night.	
	1:1 supervision for CAMHS by RMN or HCA with mental health competences	
	PEWS changed to NPEWS	
	Appendix 4 – Riverbank Escalation Plan updated	
	Appendix 5 – Telephone numbers updated	

Introduction & Definitions

1. Introduction

This operational policy aims to provide clear operational guidance for Bed management and Escalation. Incorporating escalation status for bed capacity management, and inadequate staffing due to acuity or skill mix and adverse events within the Children's Outpatients Departments. Also to provide guidance to the on call Paediatrician, Paediatric ward staff, Paediatric Clinic Staff, ED and Capacity hub decision making process when the acuity/staffing and or number of patients exceeds capacity of Riverbank ward.

Riverbank ward at WRH is a specialised paediatric inpatient ward providing an appropriate area in which paediatric patients can stay overnight. There are 35 inpatient children and young people beds in the Trust,
Within this allocation of 35 beds are:
7 cubicles
8 nursery cubicle (capable of accommodating children up to the age of 2y)
2 2 bedded rooms
3 4 bedded bays

Assessment Bay with space for 6 children. (3 beds+ 3 seats – flexible bed spaces/seats)
This finite resource requires constant management in order to:

- Effectively use the available resources to facilitate safe and timely care for children and young people whilst maintaining high quality standards and reduce clinical risk
- Ensure and provide clear guidance for the Children's Directorate nursing and medical teams in times of high activity, bed shortages, or when staffing numbers fall below a safe agreed level.
- Enable the staff who are likely to be involved in the decision to **suspend admissions** to the Children's Ward to be notified at an early stage where the potential/risk of closure has been identified.
- Ensure that the Children's Ward respond promptly and competently to any serious untoward event/major clinical incident affecting the Trust

Factors leading to bed management challenges:

- Insufficient children's trained nurses or doctors, e.g. middle grades and paediatricians (for example high patient dependency / acuity or Transport requirements for time sensitive escort which can temporarily deplete staffing levels).
- Inappropriate experience/skill mix to provide safe care
- Reduced / No available beds
- Infection in clinical areas – advised by infection control team and microbiologist
- In the event of a major incident or power failure
- Major Trust Incident

2. Policy Scope

This policy applies to all staff working within the Paediatric Directorate. This policy recognises that not all staff groups in all disciplines will have direct involvement in Bed management and escalation, however all members of staff have a responsibility to support this policy.

3. Definitions

Escalation for the purpose of this policy identifies when there are increasing levels of demand in the Paediatric Directorate, lack of bed capacity, lack of appropriate nursing skill mix/numbers/ increase demand for higher acuity patients

Normal working hours are how the trust operates on a day to day basis (Mon- Fri 0900-1700)
Out of Hours is how the trust operates between the hours of 1700- 0900 on weekdays, weekends and Bank holidays

CYP: Children and Young People Aged 0-17 years
Riverbank: 35 bedded inpatient Children's Ward
PAP/PAU: Paediatric Assessment Pathway/Paediatric Assessment Unit
RN: Registered Nurse
CHCA: Child Health Care Assistant
ED: Emergency Department
GP: General Practitioner
Orchard Services: Community Children's Nurses
OOH: Out of Hours
CAMHS: Child and Adolescent Mental Health Service

High Nurse Dependency: The CYP requires considerable staff input but is not critically ill
Side Room – single bed accommodation

High Dependency Care: is a term used to describe the child who is critically ill requiring enhanced observation, monitoring and intervention. Acuity Classifications available in Appendix 1.

Referral & Admission routes

Referral routes:

- ED
- GP
- Clinic – Urgent/ Routine/ Hot Clinics.
- Open Access: Short Term and Indefinite
- Orchard Services (Community Childrens Nurses)
- Community Midwives
- Other Acute NHS Trust referrals

Admission routes:

- Elective – Planned surgery, medical admission
- Emergency

Children's Inpatient Ward attendees:

- PAP — Paediatric Assessment pathway. Requires short period of observation, monitoring and treatment with no overnight stay. Aim for discharge within 4- 6 hours
- Inpatient — Requires on-going observation, monitoring, treatment and potential overnight stay
- Home Leave — Requires inpatient treatment, however is sufficiently clinically stable to allow home leave for a number of hours and then return to the ward for continuation of inpatient care
- Ward Attenders — Requires treatment that cannot be given by Orchard Service or Children's Outpatient Department

This policy should be used in conjunction with Guideline for the admission of Children and young persons to The Acute trust in patient ward (WAHT – TP – 055)

Delivering Same Sex Accommodation

Children, and in particular adolescents, need special consideration re: same sex accommodation. The CQC explanatory Supporting Note used to clarify key aspects of some of the essential standards for Mixed Sex Accommodation (2012) explains that:

'The hospital standard of the National Service Framework (NSF) for children requires children to be treated in accommodation that meets their needs for privacy and is appropriate to their age and development. Under the NSF, segregation by age is a more important issue than segregation by gender. This is a particular issue for adolescents, who want primarily to be with patients of a similar age and interests. In addition, they want to be able to choose between being in a single or mixed sex environment. Options should be discussed with young patients who are old enough to understand and with their parents and carers.'

Delivering same sex accommodation for young people on Riverbank is achieved by utilising the two, two bedded bays: Rooms 6 and 7 which can be used interchangeably for female / male beds.

Please be aware that for babies, children and young people, clinical need, infectious status, age and stage of development may take precedence over gender considerations

Patient Dependency / Acuity

All CYP admitted to the inpatient CYP wards will be entered on to OASIS ADT and displayed on the 'white board'. The Oasis ADT whiteboard gives ward staff the ability to achieve real time bed

management during the 24 hour period. The whiteboard functionality supports quick registration and admission of patients, facilitates TCI, transfer, physical discharge and patient search. In addition to this it is used to display 'patient dependency / acuity. This is categorised via Level 0 to Level 3. Please refer to Appendix 1 for explanatory notes.

Development of a Safer Staffing App and Ward Acuity Tool enables a ward to board overview of staffing and acuity. The daily completion of the Safer staffing app and Acuity (based on the CYP Safer Nursing Care Tool) allows further support with identifying ward staffing requirements.

In addition to the Acuity and Dependency information to inform staffing levels the inpatient CYP wards will also mirror whenever possible the RCN Standard for Staffing: General Childrens wards and depts.

Nurse Staffing Levels

No standard model exists for children and young people's inpatients wards. NQB (2018).
Children and young people's inpatient wards must have sufficient and appropriate staffing capacity and capability to provide safe, high quality and cost effective care at all times (NQB 2018). Nursing establishment is defined as the number of registered nurses and health care assistants/support workers in a particular ward, department or team.

In 'Defining staffing levels for children and young people's services'. RCN Standards for clinical professionals and service managers. (RCN, 2013) the RCN acknowledged that with 'The changing health environment, with the reduction in length of stay, increasingly indicates that the bedside care of children has little difference between day and night (Rushforth, 2008). The following standards provide an indicative baseline ratio of registered and unregistered nurses to children and young people, taking into account the distinct care requirements linked to age and development. Additional unregistered staff may be required during the day to meet the demands of the inpatient areas such as: theatre runs, ward rounds and elective admissions, as well as to provide support to family members.

The NQB (2018) refer still to the RCN levels of staffing for children for both day and night.
These are:

- Level 3 Critical care = 1:1
- Level 2 Critical Care = 1:2
- Level 1 Critical care = 1:3
- Ward Care = 1:4 if children over 2yrs of age
- Ward care = 1:3 if child under 2 yrs of age

Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring nursing care.
Children and young people should be cared for by staff who have the right knowledge, skills, expertise and competence to meet their needs.

In CYP who require high dependency care the RCN advises that the following registered nurse-to-patient ratios should be applied regardless of the setting:

- **1-2:1 RN: Patient**, for children requiring close supervision and monitoring following surgery, those requiring close observation for mental health problems or with single system problems.

- **1:1 RN: Patients**, where the child is nursed in a cubicle, has mental health problems requiring close supervision, or where the condition of the child deteriorates and requires intensive care. This higher ratio will also be required during the admission process until the child is fully admitted and stable

NQB (2018) recognises that Childrens services vary with demand and specialism. To be able to use beds flexibly it is important to create and maintain a pool of appropriately skilled staff. A correct baseline

allows absorption through peaks and troughs of activity. For inpatient services within the Paediatric Department this is as follows:

9 RN for early Shift
9 RN for Late Shift
7 RN for Night shift

2 CHCA For Early Shift
2 CHCA For Late Shift
1 CHCA For Night Shift

Within the 9 RN numbers per shift will be RN to cover the following:

RN – With sufficient experience to Clinically Co- ordinate the ward
RN – to be allocated to PAP
RN – oncology experience
RN – HDU Experience – including stabilisation CPAP/High flow
RN – multiple RN able to administer IV medication
RN – with EPLS/PILS

Nurse Staffing Escalation

There will be occasions when staffing problems may impact on bed availability, and therefore ability to maintain patient safety and flow. Please refer to Appendix 3 for Nurse Staffing Escalation
This should be used in conjunction with Childrens bed and ward staffing BRAG status. (Appendix 4)

High Dependency Care

All hospitals admitting children should be able to deliver Basic Critical Care (i.e. the more common acute presentations and clinical scenarios that require an enhanced level of observation, monitoring and intervention than can be safely delivered on a normal ward) {Ref: HDC for children – time to move on, [2013]}. This care should be delivered in a defined critical care area of the ward:

- Side rooms 4, 19 and 20

The CYP may step up and down between care levels as they progress along their clinical journey until they are ready for normal ward care and subsequent discharge home. Should the CYP fail to respond as expected, or deteriorate then their care would need to be escalated via the KIDS team (Kids Intensive Care and Decision Support – acute retrieval and advice service) and transferred to a Paediatric Intensive Care Unit if appropriate.

Side Rooms

used for:

- Infection Control
- Immunocompromised CYP
- Babies under 6 months (Privacy for breast feeding mothers, babies under 3 months who are not Breast fed do not benefit from the protection of their mother's transferred immunoglobulins.
- High Dependency Care
- CAMHS / Safeguarding requiring 1:1 supervision
- End of Life
- Complex Needs (Including Learning disabilities, autism etc)

This list is not exhaustive and flexibility is required when allocating side rooms. If it is felt that pressure on side rooms is such that it's provision is restricted, all CYP must be risk assessed for movement to a 'bay area' whilst maintaining CYP safety.

The Infection Control and Bed Management Guidelines (WAHT-INF-019) stipulate that the placement of patients in any clinical area, including single room accommodation should be risk assessed according to:

- The known or suspected organism causing infection (please refer to Paediatric Isolation Scoring Matrix WAHT-TP-083)
- The risks of transmission to others
- The severity of infection which could be caused
- The susceptibility of other patients to infection
- The reasons why patients are currently occupying single rooms (may be related to transmissible infection, the need to protect the individual from infection, or for non-infection related indications)

CYP should be assessed on a daily basis by ward staff as to whether they still require single room isolation and every effort made to arrange a final barrier clean before 7.30 pm (even if the patient is to remain in the single room) so it is ready for the next patient

Should numbers of CYP with the same infective organism impact on side room / bed availability consideration should be given to 'Cohorting' a group of patients within a multi bedded bay which can be closed from other areas of the ward. Please see cautions re cohorting in Paediatric Priority Scoring for isolation WAHT-TP-083

- Rooms 6, 7 (two bedded bays)
- Room 8 (four bedded bay)

Remember to liaise with the Infection Prevention and Control Team and take into account the impact on staffing.

Riverbank is receiving increasing admissions of CAMHS (Child and Adolescent Mental Health Service) young people who require close observation (i.e. 1: 1 RMN / Nurse within eye sight or within arm's length) to maintain their safety. Side Room 19 On Riverbank is used for CAMHS patients. This room has some anti –ligature features, but is not completely ligature free. This room is also utilised for high dependency care. There has been a small number of occasions when multiple CAMHS patients requiring 1:1 supervision has not had the requested RMN or HCA with mental health competences agency shifts filled, or when side rooms need to be re-assigned in order to meet clinical priority. In cases such as this, there must be a clear risk assessment documented and CAMHS patients transferred and cohorted to a multi-bed area whilst remaining under continued supervision.

Admissions & Referrals

Accepting admission referrals from other Children's Wards/Departments

The ward may receive requests for transfer of CYP to our inpatient areas; this may be planned (i.e. in the case of repatriation) or emergency referrals.

In all cases referrals will not be accepted unless agreed by the nurse in charge and referring speciality Consultant or 676 bleep holder (i.e. Paediatrics or Non- Paediatric teams). The nurse in charge will have an overall view of demands on beds, patient dependency / acuity, staffing etc, all of which will impact on bed availability. CYP clinical safety must be maintained.

Planned referrals from Tertiary Hospitals

The CYP will need to have MRSA and CPE swabs taken on arrival to the ward if being transferred from another inpatient facility (e.g. transfers from PICU). If a side room is available, the CYP can remain in there until MRSA and CPE swabs results are received. If a side room is not available the CYP can be nursed in a bay, providing there are no other CYP in the bay who has undergone a surgical procedure.

GP Emergency Referrals
If the referral is via a GP and the CYP address is closer to the referring hospital than to the accepting hospital they must be seen and assessed in the referring ED to ensure that CYP is clinically safe and that admission is appropriate. For CYP who live on the borders of Worcestershire County it may be appropriate for the CYP to attend WAHT, ***please note that referral should not be accepted until the Consultant/Registrar/676 Bleep holder has liaised with the nurse in charge***.

Should WAHT CYP inpatient wards have bed capacity difficulties, the above standard applies i.e. a paediatric review is offered in ED, to assess the clinical need for admission, with the caveat to the GP that the CYP will be admitted to another previously identified inpatient CYP unit who has an appropriate bed, should inpatient treatment be required. The ED will need to be informed by the Paediatric Consultant or Registrar of expected admission to their department, and will be required to review that CYP in ED to ascertain whether inpatient treatment is required. See Appendix 3 for geographical advice re GP referrals when experiencing bed crisis

Children's Ward Bed Escalation:
There will be occasions when inpatient CYP bed availability will be in demand. In order to guide staff in these situations a bed escalation plan has been devised. It consists of 4 sections:

- Green: Steady State – Normal Working
- Amber: Escalation Phase 1: Early signs of difficulty, some excess pressures requiring some additional management intervention
- Red: Escalation Phase 2: Extreme Pressure requiring immediate and significant action
- Black: Escalation Phase 3: Overwhelming critical pressures requiring intervention and action by Senior Clinical and Executive Staff

Please note that not all indicators have to be triggered in order to reach Amber, Red or black escalation phases. Use your clinical judgement in assessing the overall risk.

Please refer to Appendix 4 for Escalation Phases and Appendix 5 for Bed escalation Checklist

Unexpected/ Adverse events within Children's Clinics.
Adverse events within Children's clinic are difficult to predict.

With more procedures being undertaken i.e. Food Challenges/Chemotherapy administration and review of potentially unwell children within urgent review clinics, unexpected adverse events may occur.

Staff should raise concerns as soon as adverse/unexpected event is discovered and take steps to ensure patient safety. This may be due to patient deterioration, staff sickness leaving Clinics under required numbers to run the service effectively and safely or unexpected volume of activity generated from Clinics running.

Please see appendix 6 for flow chart to escalate adverse events within Children outpatients departments.

Appendix 1: Paediatric acuity and dependency assessment tool.

Overview of the Tool

Levels of Care	Inclusion Criteria	Guidance on care required	Specific Dependency
Level 0 Patient requires hospitalisation. Needs met through individual ward care.	Routine medical referrals/ admissions for assessment. Elective medical and surgical admissions, routine post op care, continue on-going care, patient awaiting discharge. SBAR – Situation, Background, Assessment and Recommendation.	Routine nursing assistance. 4hr TPR, 2hr visual observation Routine pre/post op care (Including 30mins observations for 2hour or until stable then hourly for 2hrs). Regular observations2-4hourly, ECG monitoring until stable, fluid management, post op oxygen therapy (max 10l).	Pews score 0-1 – use clinical observation/judgement. Existing CAMHS patient, stable. No challenging emotional/social needs. Routine care, as per Handover check list.
Level 1 Requires 2 hourly, closer monitoring, requiring more than baseline observations. **Stable.** **Level 1a** Acutely ill patient requiring intervention or are **Unstable** with **Greater potential** to deteriorate.	Observation as and therapeutic intervention. Step-down from Level 2 care. Emergency admission requiring immediate therapeutic intervention. Deterioration or change in vital signs. SBAR.	Unstable requiring more frequent observations. Head Injury's need to have ½ hourly observations for the first 2hours and then hourly for next 2hours and a fluid balance chart must be completed. Informing doctors for routine review. Oxygen therapy requirement up to 49%. Chest physio 2-6hourly. Blood gas analysis – intermittent. Insertion of Central lines or Chest drains.	Hourly Neurological, 2 hourly Neurovascular, HDU observations. Therapeutic nursing observations, however patient remains settled in mood (see therapeutic observation chart) Asthmatic – nebulisers, 1-2hourly. Oxygen between 22-49% Difficult pain control. Frequent sampling and dressings. Sedation for ward procedure. PEWS 3-6 – use clinical judgement. GCS 10-13 (A on AVPU)
Level 1b Patients who are in **stable** condition but	Severe infection, sepsis, complex wound management.	Complex drug regimes. Patients and carers needing continued support	HDU observations including continuous ECG.

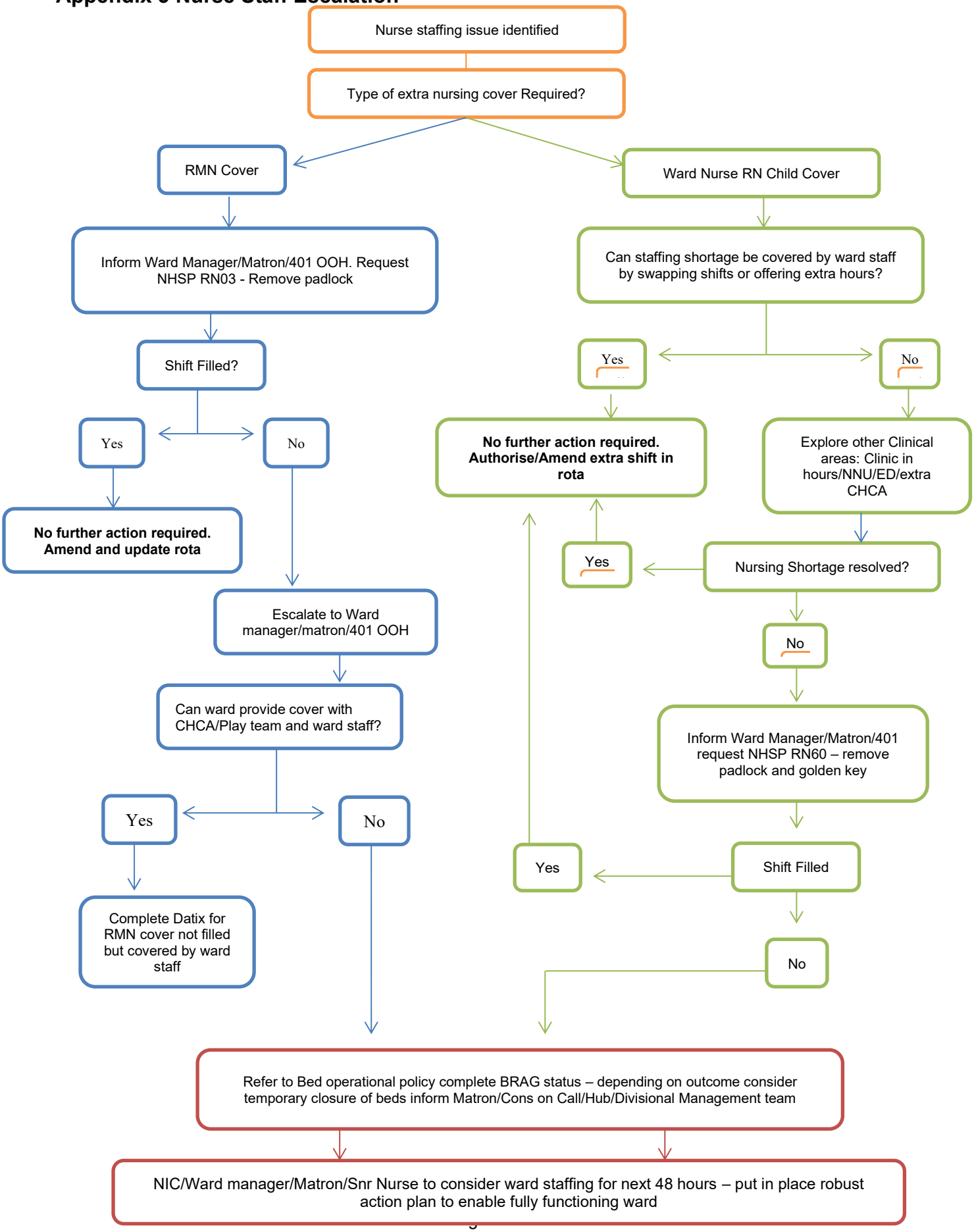
have increased dependence on nursing support.	Compromised immune system. Psychological support/preparation. Requires close observation. Mobility difficulties/complex nursing needs (see attached individual care plans). SBAR.	with concern for Clinical outcome. High dependency patient, nursing staff either 1-1 or 1-2 patient dependent for activities of daily living. HDU/therapeutic observations due to risk of harm.	Oncology patients on CVL drugs and support – Neutropenia DKA regime. Shock (10-30ml/kg fluid) – complex fluids Drains either after surgery or chest. Hourly fluid replacements. Asthmatic – nebulised adrenaline Oxygen therapy of 50% or above. HDU patient on HDU chart – complete. Meningococcal septicaemia (stable) Pain not controlled. Severe movement difficulty. PEWS 3-6 – Use clinical judgement. GCS 14-15 (V on AVPU)
Level 2 Patient who is unstable and at risk of deteriorating should be cared for by staff with the expertise and appropriate staffing level, and may need to consider or gain advice from the KIDS/anaesthetics team for possible transfer to dedicated facility/unit.	Deteriorating/compromised single organ system, post-operative. Step down from level 3 care. Uncorrected major physiological abnormalities.	Patients requiring Non-invasive ventilation/respiratory support. Requires therapeutic interventions; Greater than 60% oxygen, continuous ECG	Head box oxygen – greater than 60%, High flow oxygen, CPAP. Severe Asthmatic – IV Drugs. Therapeutic observations – 15mins, one to one supervision, however patient mood labile (see therapeutic chart). Patient awaiting tier 4 assessment/placement. Complex emotional, social or mental health needs. Severe Neutropenia

			Multiple drugs or continuous infusion (OD, poisoning/substance misuse, DKA – deteriorating conscious level, oncology, frequent blood products). Severe metabolic/fluid/electrolyte derangement. Shock (30ml/kg fluid) Recently extubated, prolonged ventilation. Prolonged/Recurrent Apnoea's. Arrhythmias, seizures. Complex anti-convulsants. NPEWS – use of clinical judgement. GCS below 9 (P and U on AVPU) Advice from KIDS and anaesthetic team.
Level 3 Patient needs advanced respiratory support and therapeutic support of multiple organs.	Monitoring and supportive therapy for compromise of two or more organ failures. Clinical deterioration, use of SBAR. Situation, Background, Assessment and Recommendation should be monitored in critical care.	Respiratory and CNS depression/compromise requires mechanical/invasive ventilation, invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/ sepsis or neuro protection.	NPEWS of 6 and above. GCS 6-10. GCS below 9 (P and U on AVPU) Airway intervention, CPR, Vasoactive, inotropic, antiarrhythmic drugs. Invasive monitoring KIDS team contacted – awaiting retrieval. Anaesthetic team should be available on ward for airway support.

APPENDIX 2: GP Advice re: obtaining a Paediatric review during an inpatient CYP bed crisis:

- For patients close to Worcester and Redditch hospitals referral for assessment in ED may be preferable. However for patients from around the county offer the following advice if bed availability is known in other hospitals:
- For the North-West of the county (Cleobury Mortimer, Bewdley, etc) consider going up towards Telford and Shrewsbury.
- For Kidderminster consider going North to Wolverhampton or North-East to Dudley.
- For the West and South (Tenbury Wells, Malvern, etc.) consider going further West towards Hereford.
- For the South-East (Upton, Pershore, Evesham) – may consider going down to Cheltenham/Gloucester.
- For Warwickshire consider going from Redditch to Warwick hospital.
- For the North-East of Redditch consider going up into Birmingham or over to the North-East (to Heartlands or Coventry

Appendix 3 Nurse Staff Escalation



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APPENDIX 4: Children's Ward Bed and Staffing Escalation Procedures: IN HOURS

BRAG	Threshold	Action	Task	Owner
Amber	•Available capacity: 2 nursery cots, 2 side rooms, 3 beds, 2 PAP beds. •1 HD CYP / CAMHS requiring 1:1. •3 CYP on PAP requiring admission. •Average wait for clerking 60-120mins. •2-3 patients outside of PAP requiring admission, plan to move within 2 hours •Significant staffing issues with minimal impact on PAP.	1. Enact escalation plan to maintain patient flow and ensure capacity	1. Optimise staff use	NIC
			2. Stop streaming ED patients/direct referrals from paramedics	NIC/RBW Consultant
			3. Escalate clinical problems to 676 bleep holder	PAP nurse
			4. Expedite PAP patient moves to RBW, escalate to ward manager if this will be >120mins . When needed and if available utilise RBW bed as assessment overspill. Put repatriations on hold. Consider cancelling Elective surgery.	PAP nurse, NIC
			5. RBW Consultant to employ alternative methods such as clerking ward rounds	RBW Consultant
Red	•Available capacity: 1 nursery cot, 2 side rooms, 1 PAP bed and movement in 4 hours. •> 1 HD CYP / CAMHS requiring 1:1. •4 CYP on PAP requiring period of observation and / admission. •Average wait for clerking 120-180mins. •3-4 patients outside of PAP requiring admission, no plan to move patient. •Significant staffing issues affecting PAP processes. •At least 1 single occupancy room space requiring Red, Violet or	1. Immediate review of safety concerns 2. RBW leaders to identify adhoc actions	1. As above plus:	
			2. Escalate/ communicate with capacity site team and ED about diverting GP expected referrals and request for Medical support to attend ED to ensure reviews.	NIC
			3. 676 bleep holder, RBW Consultant, PAP nurse, NIC (and ward manager and matron during office hours) to attend huddle and agree key actions / undertake additional ward round to support discharge. Consider redeployment of paediatric nursing and medical staff to support flow.	NIC
			4. Escalate to IPC and ISS requirement for clean and understand timescales (process can takes up to 6 hours if Red clean).	
			5. Establish capacity at nearby units and referral criteria. Admit 17 year olds to adult wards.	NIC

	Amber clean as per IPC rag rating.		6. Utilise alternative capacity to accommodate patients within the ward. E.g . Create side rooms by blocking 2 bedded bay / create nursery space by cohorting like viral illnesses	NIC, RBW Consultant
			7. Divisional managers to review actions outstanding for MFFD patients & escalate to action owners	Divisional Managers
			8. Specialty/Adult Consultants asked to review their CYP to support quick senior decision-making	Adult Consultants
Black	•Available capacity: 0 nursery cot, 1 side room, 0 PAP bed and no movement in 4 hours. •5+ CYP on PAP requiring admission. •Average wait for clerking >180mins. •4+ patients outside of PAP requiring admission, no plan to move patient.	1. Enact divert/transfer protocols if clinically safe	1. As above plus:	
			2. Non-clinical activity cancelled and clinical staff report to RBW	CD
			3. Divert ambulances/GP referrals to nearby units	WMAS, RBW Consultant
			4. Assess referred 'walk-in' ED patients and transfer to nearby unit s if admission required	RBW Consultant

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APPENDIX 4: Children's Ward Bed and Staffing Escalation Procedures: Out of hours

BRAG	Threshold	Action	Task	Owner
Amber	•Available capacity: 2 nursery cots, 2 side rooms, 3 beds, 2 PAP beds. •1 HD CYP / CAMHS requiring 1:1. •3 CYP on PAP requiring admission. •Average wait for clerking 60-120mins. •2-3 patients outside of PAP requiring admission, plan to move within 2 hours •Significant staffing issues with minimal impact on PAP.	1. Enact escalation plan to maintain patient flow and ensure capacity	1. Capacity team to work with NIC to review any staffing challenges that will support patient flow. This might also mean supporting Paeds ED if the Children's team cannot support streaming.	NIC/ Capacity Team
			2. Stop streaming ED patients/direct referrals from paramedics and will reassess in 2 hours	NIC
			3. Escalate clinical problems - Consultant will be on site until 10pm and any clinical queries will be supported by them. After these hours the Registrar will be responsible for contacting the Consultant on call for advice. N.B. the doctors resident overnight are supporting Riverbank Ward, Neonatal Unit, Delivery Suite and ED.	NIC/ On call Consultant
Red	•Available capacity: 1 nursery cot, 2 side rooms, 1 PAP bed and movement in 4 hours. •> 1 HD CYP / CAMHS requiring 1:1. •4 CYP on PAP requiring period of observation and / admission.	1. Immediate review of safety concerns	1. As above plus:	
			2. Consider any future referrals for 17 year olds and if they can be accommodated on the Adult wards.	Capacity Team
			3. Escalate to IPC and ISS requirement for clean and understand timescales (process can takes up to 6 hours if Red clean).	Capacity Team

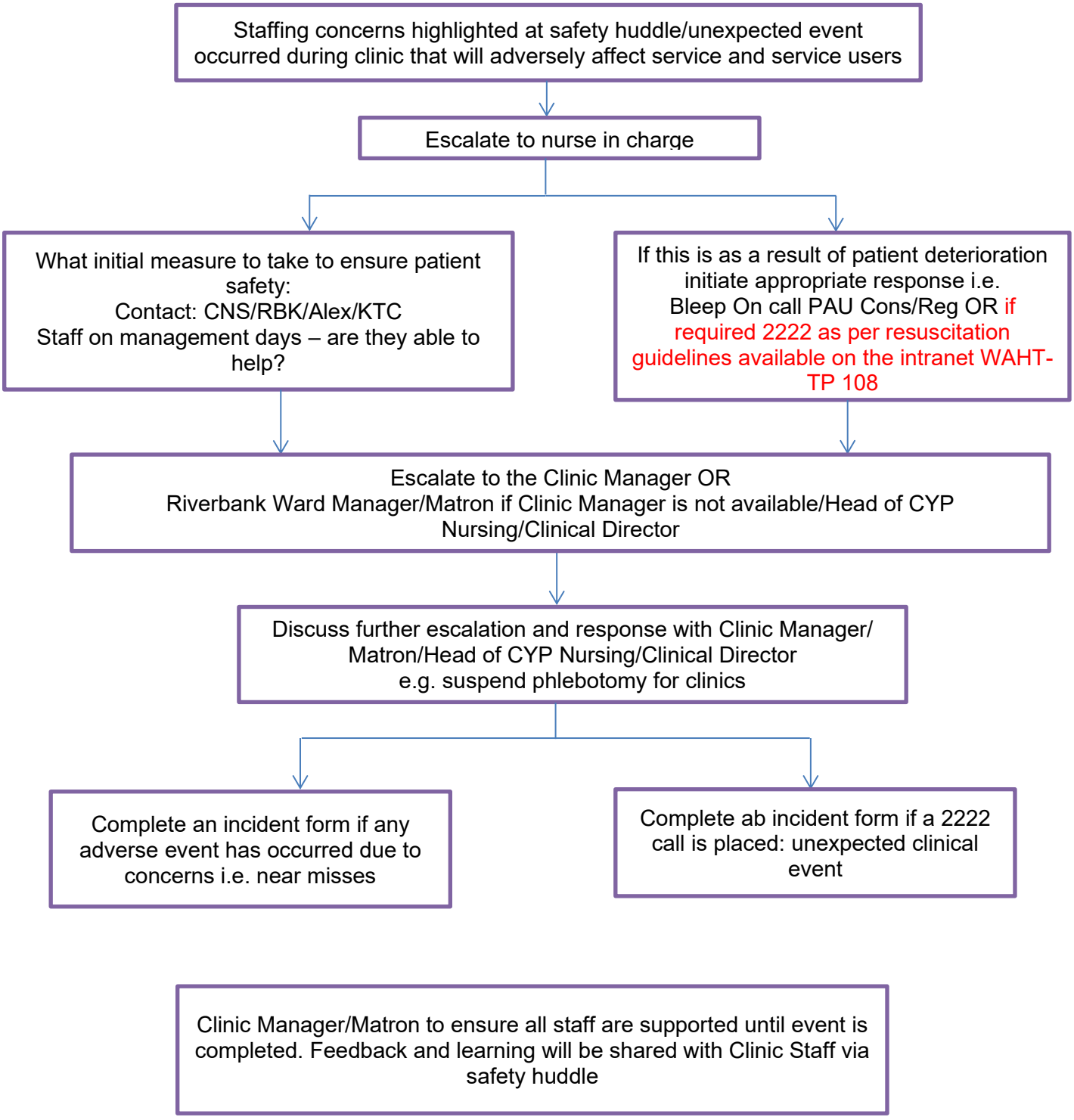
	•Average wait for clerking 120-180mins. •3-4 patients outside of PAP requiring admission, no plan to move patient. •Significant staffing issues affecting PAP processes. •At least 1 single occupancy room space requiring Red, Violet or Amber clean as per IPC rag rating.		4. Establish capacity at nearby units and referral criteria.	NIC/ Capacity Team
			5. Utilise alternative capacity to accommodate patients within the ward. E.g . Create side rooms by blocking 2 bedded bay / create nursery space by cohorting like viral illnesses	NIC
Black	•Available capacity: 0 nursery cot, 1 side room, 0 PAP bed and no movement in 4 hours. •5+ CYP on PAP requiring admission. •Average wait for clerking >180mins. •4+ patients outside of PAP requiring admission, no plan to move patient.	1. Enact divert/transfer protocols if clinically safe	1. As above plus:	
			2. Consider Ambulance diverts for under 16 year olds.	Exec on Call.
			3. Discussion regarding temporary suspension of service.	On call manager/ Exec / On call consultant

Appendix 5: Riverbank Bed/Staffing Escalation Checklist

Bed escalation phase identified: (BRAG)(Tick)				Due to:			Date: Time Started:	
B	R	A	G	Staffing	Capacity	Acuity		
Criteria				**Comment action**			**Update**	**Sign/Role**
How many CYP on ward?								
What availability is there for: Nursery cubicles Cubicles Bed (Attach SIT REP if required)				NC	Cub	Beds		
What is ward Dependency/acuity?				0	1a	1b / 2 / 3		
What are staff numbers Skill mix?				E	L	N		
What are staffing numbers for next 24 hours				E	L	N		
Is extra Nursing Staff Required				Yes		No		
Other Clinical area contacted for staff				Clinic		Y / N		
				ED		Y / N		
				NICU		Y / N		
Extra duty hours offered				Yes		No		
Shift swaps considered				Yes		No		
Escalation via Hospital Co-ordinator to request help from other area				Yes		No		
Request NHSP using code for RN60 (padlock/golden key removed				Yes		No		
Pending admissions (attach SIT REP if required)				ED	GP	OA / Elective		
Can elective list be accommodated				Yes		No – Parents informed?		
Have all patients had senior review – including all specialities				Yes		No		
Have discharges been identified?				Immediate	Potential	Later		

(Attach SIT REP if required)					
Are all referrals being routed by PAP Consultant or Consultant on Call Are all referrals being discussed with NIC					
If side rooms near/at capacity is it possible to cohort CYP to vacate side room? What impact does this have on bed availability and staffing					
Have the following been informed:	Yes	No			
Matron (Senior nurse on call if OOH)					
Consultant Paed on call					
PAP Consultant					
ED NIC					
Bed manager					
Directorate/On call Manager					
GP OOH					
HOSPITAL	**Contact/Telephone**		**Bedcover**		**How to ref**
			Bed	**Cub**	
Birmingham Childrens hospital	Bed manager 0121 333 9999				
Gloucester Royal Infirmary	07917 072 814 0300 422 8310/8308				
Hereford County Hospital	01432 364163 Switch - 01432 355 444				
Warwick Hospital	01926 495321 Ext: 4048 / 4047				
Russell Hall	# 01384 456111 ext 2703 / 2271				
Princess Royal Telford	01952 641222 Bleep 195				
Heartlands	0121 424 3389 / 0121 424 0453				
Sandwell	0121 553 1831				

Appendix 6 – Escalation for Adverse/Unexpected Events in Children's Clinic



Monitoring and Compliance

This section should identify how the Trusts plan to monitor compliance with and the effectiveness of this Treatment pathway. It should include auditable standards and/or key performance indicators (KPIs) and details on the methods for monitoring compliance.

WHAT?	HOW?	WHO?	WHERE?	WHEN?
These are the 'key' parts of the process that we are relying on to manage risk.	*What are we going to do to make sure the key parts of the process we have identified are being followed?*	*Who is responsible for the check?*	*Who will receive the monitoring results?*	*Set achievable frequencies.*
	Clinical Audit	Paediatric Clinical Governance Committee		Every 12 months
	Staff Electronic Record system	Local Managers/Staff		8-10 weeks
	Clinical Audit/Observation	Paediatric Clinical Governance Committee		
		S Weale, K Haley & R Delves		Yearly
	Review of Datix and completed "escalation trigger list"	Nursing Staff		
	6 Monthly Audit	CYP Nursing and Medical Staff		6 monthly
Viewing Arrangements	Spot checks	Children's wards or Emergency Departments	CYP Standards Committee, escalating to Trust Children's Board if required	Three times a year
Documentation – Completion of Checklist: Following the death of a CYP in hospital. Professional Contact List	Audit of checklists via CYP medical records	Children's Wards or Emergency Departments	CYP Standards Committee, escalating to Trust Children's Board if required	Three times a year

References

- CQC Supporting note: Mixed sex accommodation (2009)
- National Quality Board (2018) Safe, sustainable and productive staffing: An improvement resource for children and young people's inpatient wards in acute hospitals Edition 1. NHS Improvement
- Royal College of Nursing. (2013) Defining staffing levels for children and young people's services'. London.
- Royal College of Paediatrics and Child Health, Paediatric Intensive Care Society, Royal College of Anaesthetists, Association of Paediatric Anaesthetists, Royal College of Nursing, Intensive Care Society, British Association of General Paediatricians, WellChild and NHS Commissioning Board representatives. (2013) **HIGH DEPENDENCY CARE FOR CHILDREN – TIME TO MOVE ON:** A focus on the critically ill child pathway beyond the paediatric intensive care unit

To be used in conjunction with:

Paediatric Priority Isolation Scoring for Isolation WHAT – TP – 083

Infection control WAHT – INF- 019

Guideline for the admission of Children and young persons to The Acute trust in patient ward (WAHT – TP – 055)