TRUST POLICY FOR CAPACITY ESCALATION PLAN FOR INPATIENT WARDS, CED AND NICU – UHDB (Derby & Burton)

<table>
<tr><td>Reference Number

RKM = Risk Management</td><td colspan="2">Version:

No Changes V2.2</td><td>Status

Final</td><td>Author:

Laura Churm – Lead Nurse</td></tr>
<tr><td rowspan="3">Version / Amendment History
Major Changes = V2.1 on 27.04.21</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>V2.2</td><td>13.01.22</td><td>Laura Churm</td><td>To include escalation plans and action card for children with challenging behaviour</td></tr>
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<tr><td colspan="5">Intended Recipients: All Paediatric staff and Trust Operations team</td></tr>
<tr><td colspan="5">Training and Dissemination: Circulate link via e-mail and print and distribute action cards</td></tr>
<tr><td colspan="5">To be read in conjunction with: Trust Full Capacity Plan Final Version 2.0

Infection control policy

Trust policy for patient transfer

Maternity & Neonatal services escalation plan (including temporary suspension of maternity services.</td></tr>
<tr><td colspan="5">In consultation with and Date: Trust Operations team April 2021, W&C Divisional Delivery Group 25th May 2021</td></tr>
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stage Two Completed No</td></tr>
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<tr><td colspan="3">Contact for Review</td><td colspan="2">Laura Churm – Lead Nurse</td></tr>
<tr><td colspan="3">Executive Lead Signature</td><td colspan="2">Executive Chief Operating Officer</td></tr>
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CAPACITY ESCALATION PLAN FOR INPATIENT WARDS, CED AND NICU

Contents

Section	Page No
Introduction	**4**
Escalation plan structure	**4**
National Guidance/targets	**4**
Trust escalation levels	**4-6**
Key contacts- telephone numbers	**6**
Operational management arrangements	**6**
Bleep Holder Responsibilities	**6**
Nurse In Charge Responsibilities	**6**
Cancellation of surgery	**6**
In hours/out of hours arrangements	**6**
Moving patients within paediatrics • Ward to ward transfers within paediatrics • Transfers between paediatric and adult wards • Infection control precautions	**6-7**
Challenging Behaviour and Mental Health Presentation in CED Flow Chart	**8**
Inpatient wards	**9**
High dependency beds	**9**
Derby PCCU Flow Chart	**10**
Neonatal intensive care (Calculation of Staffing to Acuity)	**11**
CED Escalation Plan	**11-12**
Clinical Triage times	**12-13**
Other relevant documents	**14**
Escalation Plans	
• 1A: CED Nurse in charge	**15**
• 1B: CED Senior Doctor On Duty	**16**
• 1C: CED Nurse in charge (for patients already in department)	**17**
• 1D: CED Senior Doctor On Duty (for patients already in department)	**18**
• 1E: PAU Nurse in charge	**19**
• 1F: PAU Senior Doctor On Duty	**20**
• 1G: Paediatric Bleep Holder	**21**
• 1H: Nurse in charge Inpatients Wards	**22**
• 1I: Senior Management Team (In Hours)	**23**
• 1J: Service Week Consultant	**24**
• 1K: NICU Coordinator/ Nurse in Charge Derby and Burton	**25**
• 1L: NICU Consultant Derby	**26**

INTRODUCTION

This policy outlines the arrangements in place and key actions to be taken by members of staff to effectively manage bed capacity to accommodate neonatal and paediatric emergency admissions at University Hospitals of Derby and Burton (UHDB). It is designed to ensure equality of access based on clinical based regardless of site of presentation. It is to ensure that potential risk to patients is minimised and that excellent quality of care is maintained. The guideline has been designed to ensurethat both emergency and elective government targets are achieved.

The escalation plan is split into four levels, which reflect the current status of the hospital in terms of bed availability, staffing and level of emergency demand. Actions at each level must be completed before moving onto the next level.

The aim of the guideline is for the paediatric business unit to have clear escalation guidance.

ESCALATION PLAN STRUCTURE

The paediatric business unit escalation plan has overarching actions for key members of the paediatric service depending on the level of escalation and links in with the Trust Full Capacity Plan Final Version 2.0.

NATIONAL GUDIANCE/TARGETS

In line with national SIT-REP guidance the following are recorded within the trust:

1. All ED/CED attendances:- Waiting time from arrival in ED to discharge, admission, Transfer – 95% within 4 hours
2. All emergency admission:- Waiting time from the time the decision has been made to admit to the time of transfer to appropriate area. (The second measure is referred to as a trolley wait) – 100% within 12 hours
3. Elective admissions:- no patients wait more than 18 weeks from referral to treatment by April 2008. All patients who are cancelled for non-medical reasons to be re-admitted within 28 days
4. No (0%) delays to discharge from hospital
5. Complications to 85% triage within 15 minutes of attendance as per RCPH national standards
6. Neonatal exception reporting:- for babies born outside of the agreed service specification

TRUST ESCALATION LEVELS

Operational pressures Escalation level	Internal Status	Description
OPEL 1	GREEN	**Low risk** Capacity is such that the organisation is able to maintain patient flow and is able to meet anticipated demand within available resources
OPEL 2	AMBER	**Moderate risk** and signs of pressure The organisation is starting to signs of pressure. Focussed actions are required to mitigate further escalation. Enhanced co-ordination and communication will alert the whole system totake appropriate and timely actions to reduce the level of pressure as quickly as possible – and return to green status as quickly as possible
OPEL 3	RED	**High Risk** and Major Pressure Actions taken in

		OPEL3 have failed to de-escalate the system and pressure is worsening. The hospital is experiencing major pressures compromising patient flow and continues to increase. Further urgent actions are required across the organisation by all partners. The may include escalation to the Trust Full Capacity plan.
OPEL 4	BLACK	**Very high** risk and critical pressure All actions have failed to contain service pressures and the hospital is unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be led and taken at Director level until de-escalation to RED is achieved. This may include escalation to the trust full capacity plan. The COO or executive on- call must be alerted and consulted

Escalation status	**Status descriptor**	**Responsibility for internal management (chair of operational meetings)**	**Responsibility for external communications**
Level Green: (Normal working)	Capacity is such that the organisation is able to maintain patient flow and is able to meet anticipated demand within available resources.	Patient flow manager	Head of operations/ senior manager on call
Level Amber: (moderate pressure)	The organisation is starting show signs of pressure. Focused actions are required mitigate further escalation. Enhanced co-ordination will alert the whole system to take appropriate and timely actionsto reduce the level of pressure as quickly as possible	Head of operations/senior manager on call	Head of operations/ senior manager on call
Level red: (extreme pressure)	Actions taken in OPEL3 have failed to de-escalate the system and pressure is worsening. The hospital is experiencing major pressures compromising patient flow. Further urgent actions are required across the organisation by all partners.	Head of operations/senior manager on call	Chief operating officer (or deputy)/executive on call (or deputy)
Level Black: (Critical Pressure)	All actions have failed tocontain service pressures and the hospital is unable to deliver comprehensive care. Decisive action must be led and taken at Director level until de-escalation to RED is achieved. The chief executive MUST be alerted and consulted when the trust is on level black escalation.	Chief operating officer (or deputy)/Executive on call (ordeputy)	Chief operating officer (or deputy)/Executive on call (or deputy)

A Trust operational meeting occurs daily at 09:00, 12:00, 16:00 and 20:00. The Trust escalation level is calculated at each of these meeting with the exception of the 09:00 meeting. At 09:00 a separate detailed organisational update which details the inpatient ward position as well as other key information is shared across the trust by e-mail.

The level of escalation for the paediatric service is calculated using the criteria stated within the body of this policy and the criteria will differ depending on the areas concerned i.e. in-patient paediatric wards, PCCU, CED and NICU.

KEY CONTACT TELEPHONE NUMBERS

To contact senior managers out of hours, either within paediatrics or within the trust contacts the switchboard by dialling '0'.

The switchboard can connect callers to the home phones or mobile phones of senior managers. There is a designated bleep-holder within paediatrics who is present on site 24 hours a day.

OPERATIONAL MANAGEMENT ARRAGEMENTS

Operational Managers or their deputies, are required to attend bed meeting when the trust escalation level is amber or above. The operational mangers review the outcome of the bed meetings and escalate actions as necessary.

BLEEP HOLDER RESPONSIBILITIES-

The paediatric bleep-holder should report the current bed-state across the UHDB children's footprint, planned discharges and any problems prior to each meeting. The bed-state template should be maintained and kept within the paediatric bleep-holder folder. See action card.

For all bed meetings, the trust escalation level, the bed state and associated actions from the meetings will be recorded and sent throughout the trust via email to members of the urgent care distribution. See action card.

NURSE IN CHARGE RESPONSIBILITIES- see action card

CANCELLATION OF SURGERY

Elective admissions: No patients should wait more than 18 weeks. All patients who are cancelled for non-medical reasons must be re-admitted within 28 days. The decision to cancel any elective or day-case procedure due to bed capacity pressures within paediatrics must be made through the paediatrics General Manager or Divisional Director in discussion with the service week consultant.

Cancellations will only be made once all other options have been explored.

IN HOURS/OUT OF HOURS ARRAGEMENTS

Within the paediatrics business unit, all actions primarily should be reported to the paediatric bleep-holder who will escalate accordingly to Paediatric senior management team in hours (8am – 6pm) and the on-call management team out of hours.

MOVING PATIENTS

Ward to ward transfers within paediatrics

Any decision to move patients from ward to ward (within or between sites) must be discussed beforehand with paediatric bleep-holder to ensure the patient can be accepted by the paediatric or

neonatal medical team and, be in line with the trust policy for patient transfers e.g. evidence of good communications and contemporaneous documentation to support safe transfers.

Transfers between paediatric and adult wards

Any decisions to move a paediatric patient to an adult bed must be discussed beforehand with the paediatric consultant on service week and take into consideration the impact on a young person and their personalised transition plan being cared for in an adult environment.

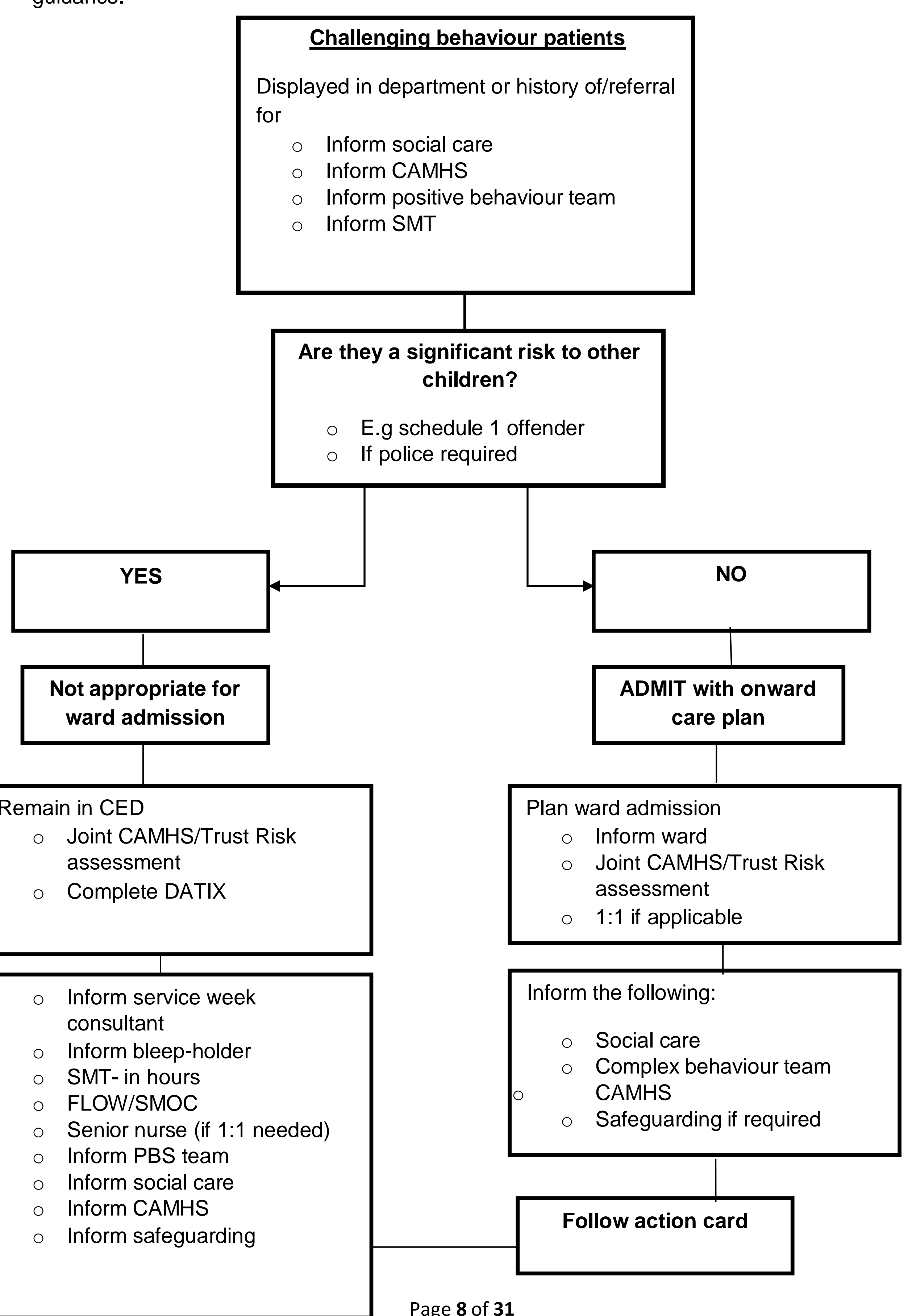
Infection control precautions

When identifying suitable beds for patients to be admitted to, infection control precautions must be adhered to at all times, according to trust's infection control policy. All patients with a suspected infection must be isolated accordingly, in line with the infection control policy. If a side room is required for an emergency admission/patient requiring barrier nursing and one is not available, the infection control team (in-hours) must be contacted to identify which patients across the trust may be transferred out of the side rooms. Out of hours the microbiologist must be contacted. Updates on infection control issues are given to the site management team manager AM and PM Monday to Friday for discussion at the site meetings.

Continue to next page for - CHALLENGING BEHAVIOUR AND MENTAL HEALTH PRESENTATION IN CED.

CHALLENGING BEHAVIOUR AND MENTAL HEALTH PRESENTATION IN CED

Default position for all children is to admit for a place of safety in accordance with NICE guidance.



Medically fit patients – delays to discharge

Derby

Level working	Trigger	Department status
Level Green: OPEL 1 (Normal working)	○ No medically fit patients in delay	Normal activity
Level Amber OPEL 2 (Moderate Pressure)	○ Max of 2 patients medically fit awaiting placement/package on acute ward	Persistent Excess pressure requiring additional action
Level Red: OPEL 3 (Extreme Pressure)	○ Max of 3 patients medically fit on acute ward, OR ○ 1 (or more) patient with challenging behaviour held in CED (as per flowchat page 8)	Severe/prolonged excess pressure requiring support
Level Black: OPEL (Critical Pressure)	○ 4 or more patients medically fit	Extreme pressure requiring urgent support

Burton

Level working	Trigger	Department status
Level Green: OPEL 1 (Normal working)	○ No medically fit patients in delay	Normal activity
Level Black: OPEL (Critical Pressure)	○ 1 patient medically fit in delay	Extreme pressure requiring urgent support

INPATIENT WARD - activity

The aim is to ensure adequate bed availability in children's inpatients areas including Ward 2, Dolphin, Puffin and Sunflower to accommodate emergency, non-elective and elective patients.

The following are triggers and actions to be taken when bed availability is reduced.

Discuss with the service week consultant regarding elective operations/activity at the morning board round.

It is the bleep-holders responsibility to refer to the Shelford Acuity tool to determine staffing levels verse acuity across the business unit.

Level working	Trigger	Department status
Level Green: OPEL 1 (Normal working)	○ Over 5 beds available ○ Over 5 discharges later	Normal activity
Level Amber OPEL 2 (Moderate Pressure)	○ 1-5 beds available ○ Under 5 discharges	Persistent Excess pressure requiring additional action
Level Red: OPEL 3 (Extreme Pressure)	○ 0 beds available ○ Discharges expected within 4 hours to meet current need	Severe/prolonged excess pressure requiring support
Level Black: OPEL (Critical Pressure)	○ 0 beds available ○ Queuing in CED ○ 0 discharges later	Extreme pressure

PCCU BEDS

Please refer to the PCCU policy.

Unit staffing ratios:

Level of care	Level 3	Level 1	Level 2	Step Down
Nurse to patient ratio	1:1 while awaiting retrieval	1:2	1:2	1:2

	Patients	Staff required
No of Level 3 patients/isolation (1:1)	2	2
No of Level 2 patients (2:1)	1	0.5
Total	3	2.5

Staff Avalibale	3
Sum	0.5

If sum is 0 (no beds) and no potential discharges
If sum is 0 (no beds) but there are potential discharges
If the sum Is 0.5 and there are potential discharges
If the sum Is above 0.5

GREEN	• All PCCU and step down beds open • Full / safe staffing levels • Potential to step down/discharge	• Knowledge of bed situation and potential discharges identified pre ward round • AM and PM discharges confirmed and documented on PCCU Daily Admission and Review during ward round and appropriate ward areas notified. • Maintain Safe Care accurately and timely at least TDS • Assess staffing levels over next 48 hours for early identification and escalation. (Escalate to Band 7 or Bleep holder if shortfalls not resolved) • Early identification of patients requiring escalation of care via PEWS and timely communication between areas • Nurse in charge checklist completed • Nurse led patient safety huddle twice daily

AMBER	• 1 PCCU bed Step down bed (s) available • Potential to step down or discharge within 4 hours	• Identify delays to discharge and escalate to the Bleep Holder if unable to resolve at unit level • Conduct additional safety huddles • Consider options for moving suitable patients to other ward areas
RED	• No PCCU or Step Down bed • Discharge probable within 8 hours	• Discuss options for opening beds • Inform CoMET of lack of bed availability
Black	• No bed availability • No discharges within the next 12 hours	• Discuss potential for opening more beds with the Bleepholder

Level 1 and Step Down patients do not necessarily require a QIS RN but this should be assessed on a patient by patient basis

For the first hour following admission patients require a 1:1 staffing ratio. This will be managed flexibly with the normal staffing numbers, however, there will not be capacity to take 2 admissions within the same hour.

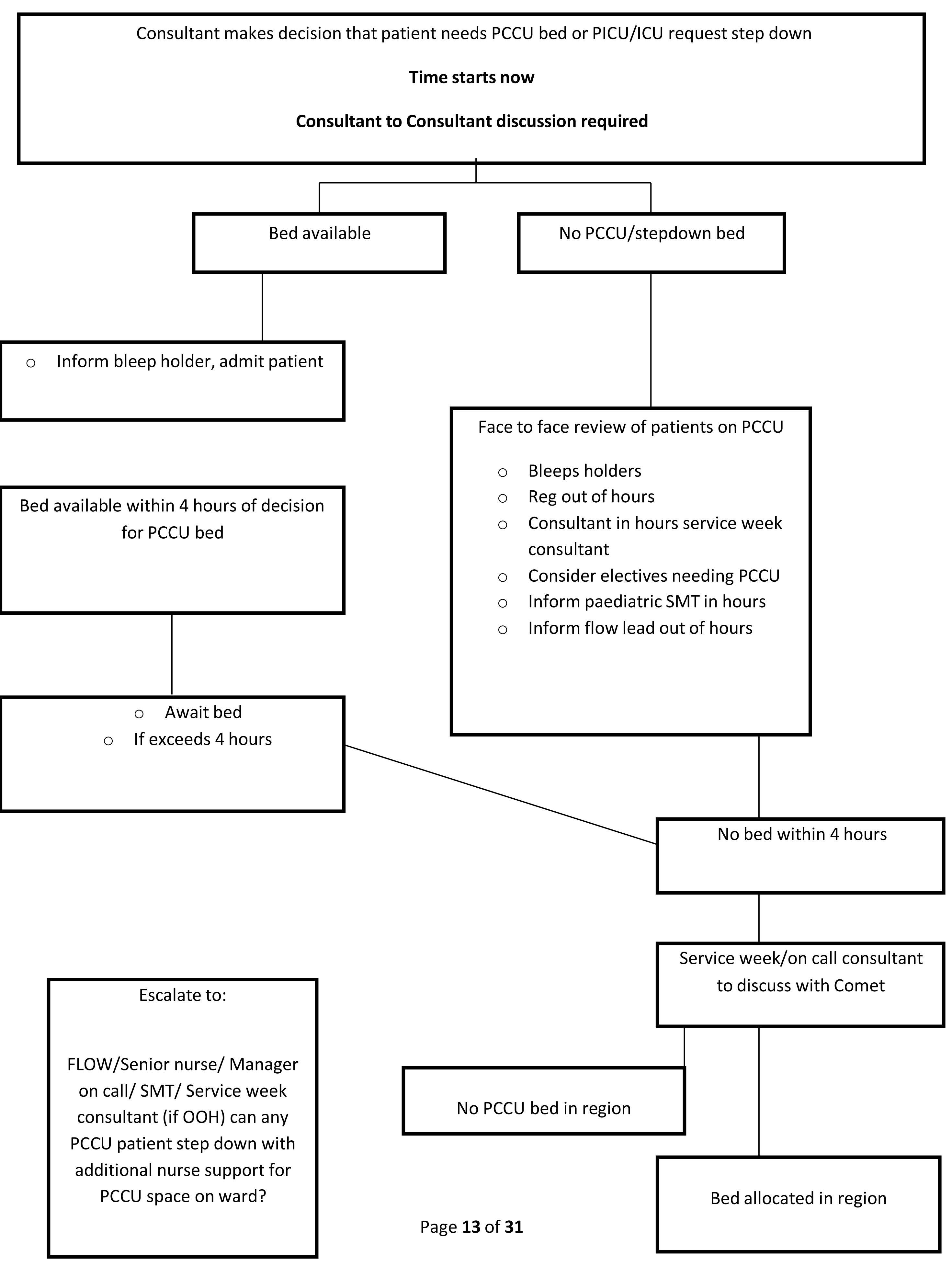
Staffing ratios will need to increase to 1:1 (and at times 2:1) in the following circumstances:

- Use of a cubicle / Rediroom with infection control precautions
- Resuscitation and intubation and ventilation scenarios

Minimum staffing levels 2 RN qualified in speciality (QIS)

Once a decision that a patient requires PCCU has been made by the consultant please follow the flow chart below.

PCCU at RDH



Neonatal Services

Proactive management of capacity is essential to optimising patient flow within the trust, ensuring that babies are cared for in the most appropriate place and as close to home as possible. Each unit should consider, whether babies are in the most appropriate cot at least once daily, between the attending consultant and nurse in charge. The timely repatriation or transfer of babies for continuing care and the referral of babies to paediatric services at 40 weeks, rather than waiting until 44 weeks to begin the process should also be considered. Maternity in-utro transfers carefully managed aware across both site

Nurse staffing along with cot availability needs to be considered. Below is the agreed network calculation to assist the clinician/ nurse in charge to assess the overall status of the neonatal unit.

LNU/ SCBU								
Number of nurses available	-	Number of level 1 babies	-	Number of level 2 babies ÷ 2	-	Number of level 3 babies ÷ 4	=	X
Example: 5 RN's	-	2 level 1 =2	-	2level 2 babies ÷2 = 1	-	8 level 3 babies ÷ 4= 0.75	=	1.25

The X number will then help quantify the current unit status.

X	Number	And/ Or	Cot availability	Status
X	**≥ 1**	**And**	Emergency Cot + one or more additional cots at any levels	Green
X	**Between 0-1**	**And/ Or**	ITU/ HDU/SC cots and resuscitation space available	Amber
X	**< 0**	**And/ Or**	ITU/ HDU cot only and resuscitation space	Red
X	**< 0**	**And/ Or**	Resuscitation space only	Black

*for the QHB site please bear aware of the footprint of the unit and bear in mind staffing levels reured for each room.

CED and PAU ESCALATION PLAN

Purpose

This document is intended to ensure the department provides the most effective response to high levels of activity, at any given time.

CED

Operational pressures Escalation level	Internal Status	Description
OPEL 1	GREEN	**Low risk** Resus beds available Less than 2 patients waiting for triage Clinical review within time as determined by triage There are less than 20 patients in the department. 4 hour target is met
OPEL 2	AMBER	**Moderate risk** Resus beds available If there are 3 or 4 patients waiting for triage If patients aren't being seen within their time determined by triage category (see category table below) but the category 2 cohort are being seen within 20 minutes There up to 36 patients in the department
OPEL 3	RED	**High Risk** Resus beds available There are 5 -10 patients waiting for triage Triage category 2 cohort are waiting more than 1 hour for a clinical review There are 37 - 44 patients in the department
OPEL 4	BLACK	**Very high** No resus space There are 11 or more patients waiting to be triaged

Clinical triage times

Category 1	Immediate
Category 2	Within 20 minutes
Category 3	Within 1 hour
Category 4	Within 2 hours
Category 5	Within 4 hours

PAU

Operational pressures Escalation level	Internal Status	Description
OPEL 1	GREEN	**Low risk** Stabilisation space available Less than 2 patients waiting for triage Clinical review within time as determined by triage There are 6 or less patients waiting in PAU. 4 hour target is met
OPEL 2	AMBER	**Moderate risk** PCCU bed available (at RDH) More than 2 patients waiting for triage If patients aren't being seen within their time determined by triage category (see category table below) but the category 2 cohort are being seen within 20 minutes There are between 7-10 patients in the department
OPEL 3	RED	**High Risk** PCCU bed available (at RDH) There are 3-5 patients waiting for triage Triage category 2 cohort are waiting more than 1 hour for a clinical review There are more than 10 patients in the department
OPEL 4	BLACK	**Very high** There are 6 or more patients waiting to be triaged

Implementation

Prior to consulting steps in plan please consider the following.

1 Where is the pressure? Triage, departmental, admission

2 What is my resource?

3 Is staffing in the department unsafe?

4 What is the acuity score- 1 patient in resus may take 2 nurses and even if not busy at time in main department this should be escalated early to get nursing help ***before*** the department is under strain.

Pressure in triage will require a different level of escalation and sequence of steps to general business in the department – it is therefore important to identify this.

Equally if not managed well, pressure in 1 area of the department will end up causing effect to the next point in the patient pathway, and it is important to anticipate this.

A consultant see and treat stream is very useful to get the "queue down" but if there is no other decision maker in the department this would leave the possibility of a lot of patients left without a decision. Thus this stream should not be considered unless the only pressure in the department is on patients waiting to be seen or triage or once a second decision maker is in the department ie paediatric registrar.

Though the escalation tables below are separated for ease of reference, at times of high pressure it is likely that there will be pressure on both parts of the department- appropriate action for both should be put in to action.

If there are clinical safety concerns with the department, the non-resident paediatric Consultant should be made aware by the registrar or senior doctor. If the registrar is unavailable, the caller should be able to state why they are unavailable. NB. If there are significant concerns regarding patient safety consideration should be gives as to whether the neonatal registrar could be released to assist. This needs to be a consultant to consultant discussion.

The conversation should include the following key information:

1 Problems on the ward

2 Number of patients waiting to be seen, waiting for triage and a breakdown of their triage categories.

3 Current 'wait to be seen'

4 Staff present

OTHER RELEVANT DOCUMENTS

Other documents should be referred to in conjunction with the escalation policy, as directed within this document. The major incident policy must be followed when a major incident is declared and the trust business continuity plan must be implemented when an internal incident is declared. The following policies must be adhered to:

1 Infection control policy

2 Trust policy for patient transfer

3 Maternity & Neonatal services escalation plan (including temporary suspension of maternity services.

APPENDIX 1A: CED TRIAGE escalation

ACTION CARD: NURSE IN CHARGE

CHILDRENS EMERGENCY DEPARTMENT TRIAGE - RDH

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto the next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN OPEL 1
• Designated triage nurse for each stream • Consider opening up second triage stream
AMBER- OPEL 2
• Open second triage stream already in progress • If triage mainly injury open ENP stream to pull all minor trauma through • If triage mainly illness, second nurse to start triaging in room 2 • Pull HCA from observation ward to speed up triage by doing observations etc • Inform site manager and flow team- ask for additional nursing help to prepare patients for admission/ replace cover on observation ward. • Ambulance crews to hand over directly to doctor in department. • Joint triage with senior doctor and HCA • Ring paediatric bleep-holder to ascertain activity there- do they have capacity to accept our GP referrals if we go to a divert
RED- OPEL 3
• Assume all points above already in action • **STOP**- what is waiting? • **MINOR INJURY-** ENP and consultant to set up see and treat streams as well as current triage stream (consultant in room 6, ENP room 9) • **MAINLY ILLNESS-** ACENP and consultant with HCA to see and treat • Senior manager on call to be informed of status • Discuss with bleep holder and consider divert to Burton • Submit IR1 via datix
BLACK- OPEL 4
• Consultant discussion with Executive Director On Call to request closure of department (ie redirecting ambulances until safe) • Submit IR1 via datix

APPENDIX 1B: CED ESCALATION

ACTION CARD: SENIOR DOCTOR ON DUTY

CHILDRENS EMERGENCY DEPARTMENT TRIAGE

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions, all actions for any previous levels must be taken before moving onto to the next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN- OPEL 1
• Normal practice
AMBER- OPEL 2
• Ensure nursing plan is in action • Identify patients in department > 180 mins have clear plan in place ie bed booked, TTA ordered • Start taking handover and CED consultant led see and treat of ambulance patients
RED- OPEL 3
• Ensure nursing plan is in place • Call down paediatric registrar to continue senior review of patients in department to allow consultant to see and treat • If registrar unable to attend they should ring the general paediatric consultant to identify alternative options and liaise with neonatal consultant to see if further medical staff can be released.
BLACK- OPEL 4
• Consultant discussion with executive director on call considers closure of department

APPENDIX 1C: CED ESCALATION

ACTION CARD: NURSE IN CHARGE

CHILDRENS EMERGENCY DEPARTMENT

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN- OPEL 1
• Designated triage nurse
AMBER- OPEL 2
• Ensure triage is safe and sustainable • Prepare admission packs for all patients likely to require admission. • Inform paediatric bleep holder. • Identify all patients in department for > 180 minutes- have they got a plan? Could they go to Obs ward? • Do they need any ongoing treatment? • Consider direct referral to specialty • Consider dedicating HCA to performing repeat observation on everyone in department • Ring paediatric bleep holder to ascertain Burton activity. Do they have capacity to accept GP referral if we go on divert?
RED- OPEL 3
• Assume all points above already in action • **STOP-** what is waiting? • ***Minor injury*** -ENP and consultant to set up see and treat streams as well as current triage stream (consultant in room 6, ENP room 9) • ***Mainly illness*** -ACENP and consultant with HCA to see and treat (ACENP room 5, consultant room 6) • ***A child in resus and high pressure on shop floor*** -can dolphin send someone down to help? -can ward send down a nurse to relieve in observation ward to allow observation ward (CED) nurse to help in resus • Paediatric Senior Management team/ Senior Manager On Call to be informed of status • HCA to prepare admission packs • Flow to help with ward transfers • Identify patients with POPS<2 or triage 4 or 5 who may be suitable for next day review and show to consultant • Discuss with paediatric bleep holder and ask to divert GP activity to Burton within their PAU opening hours
BLACK- OPEL 4
• Discuss with CED consultant and Executive Directory On Call to request closure of the department i.e redirect ambulances until safe

APPENDIX 1D: CED ESCALATION

ACTION CARD: SENIOR DOCTOR ON DUTY OR PAEDIATRICAN ONCALL

CHILDRENS EMERGENCY DEPARTMENT

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN – OPEL 1
• Normal practice
AMBER- OPEL 2
• Inform paediatric registrar of increased pressure • Set up a consultant led see and treat stream • Ask AED senior if any help available
RED- OPEL 3
• Ensure nursing plan and above steps are in place • Call paediatric registrar to CED • If registrar unable to attend, registrar or CED senior should inform general paediatric consultant to be called to identify alternative options and liaise with neonatal consultant to see if further medical staff can be released. • See nursing action- if sick child on ward or CED call general paediatric consultant to take over and allow senior decision maker to take charge of department • Senior led direct referral to specialty • Review notes of patients with nurse in charge of patients POPS<2 or triage 4 or 5 or awaiting urine/ bloods results- consider next day obs ward review, referral back to GP.
BLACK- OPEL 4
• Discussion with CED consultant and Executive Director on call requesting closure of department ie redirecting ambulances until safe

APPENDIX 1E: QHB PAU ESCALATION

ACTION CARD: NURSE IN CHARGE

Paediatric Assessment Unit

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN- OPEL 1
• Designated triage nurse
AMBER- OPEL 2
• Ensure triage is safe and sustainable • Prepare admission packs for all patients likely to require admission. • Inform paediatric bleep holder. • Inform Service week Consultant or On Call Consultant of pressure in PAU • Identify all patients in department for > 180 minutes- have they got a plan? Could they go to Obs ward? • Do they need any ongoing treatment? • Consider direct referral to specialty • Consider dedicating HCA to performing repeat observation on everyone in department • Ring paediatric bleep holder to ascertain Derby activity. Do they have capacity to accept GP referrals if we go on divert? • Consider pulling ED Nurse back to PAU following discussion with ED Nurse in charge
RED- OPEL 3
• Assume all points above already in action • Call the Service Week or On Call Consultant to the department • **STOP-** what is waiting? • ***A child in PCCU and pressure on the shop floor*** -can NNU send someone down to help? -can the ward send a HCA to support • Paediatric Senior Management team/ Senior Manager On Call to be informed of status • HCA to prepare admission packs • Identify patients with POPS<2 or triage 4 or 5 who may be suitable for next day review and show to consultant • Discuss with paediatric bleep holder and ask to divert GP activity to Derby within their PAU opening hours
BLACK- OPEL 4
• Discuss with Consultant and Executive Directory On Call to request closure of the department

APPENDIX 1F: QHB PAU ESCALATION-

ACTION CARD: SENIOR DOCTOR ON DUTY

Paediatric Assessment Unit

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions, all actions for any previous levels must be taken before moving onto to the next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN- OPEL 1	
•	Normal practice
AMBER- OPEL 2	
•	Ensure nursing plan is in action
•	Identify patients in department > 180 mins have clear plan in place ie bed booked, TTA ordered
•	Inform Service week Consultant or Consultant on Call of pressure within PAU
RED- OPEL 3	
•	Ensure nursing plan is in place
•	Call Paediatric Consultant to department
BLACK- OPEL 4	
•	Consultant discussion with executive director on call to request closure of department

APPENDIX 1G: ACTION CARD

ACTION CARD: PAEDIATRIC BLEEP HOLDER

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN- OPEL 1
• Knowledge of the paediatric bed situation across UHDB • Knowledge of patients in CED, PAU and Burton ED • Knowledge of safe care (staffing and acuity) • Be able to identify admissions, planned discharges and any delays to discharge. • Identify any children or young people with challenging behaviours and any patients requiring increased supervision • Provide the BU and trust with updates regarding via email at 08:30, 11:30, 15:30 and 17:30 • Attend the most appropriate bed meetings at either site as required at 12:00 and 16:00 • Attend the board round at 09:00 • Attend Dr handover at 16:30 • Link with the SMT Lead regularly
AMBER – OPEL 2
• Identify on day discharges and determine am or pm • Identify transfers in, both planned and imminent and any potential transfer out • Identify delays to discharge which cannot be resolved at ward level and escalate to senior management team. • Consider increasing staffing level to create more capacity • Attend staffing meeting at 13:00 depending on need, if you need to attend both then discuss with SMT lead. • Link with the SMT Lead regularly
RED – OPEL 3
• Inform senior management team in hours/ flow team out of hours • Discuss with SMT/Flow extra staffing to open additional beds • Speak to service/ ward consultant and arrange additional ward round • Discuss with the service week consultant re. Elective operations/ activity to be discussed at the morning board round. • Link with the SMT Lead regularly
BLACK
• Continue to monitor the situation maintaining communication with the wards, service week consultant, CED and senior management team in hours/ Flow team out of hours

APPENDIX 1H: ACTION CARD

ACTION CARD: NURSE IN CHARGE INPATIENTS WARD

NURSE IN CHARGE

PAEDIATRIC BUSINESS UNIT

This action card summarises your role as nurse in charge or your inpatient area. All actions for any previous levels must be taken before moving onto next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN- OPEL 1
• Knowledge of the bed situation in your clinical area • Identify on day discharges and determine am or pm • Identify transfers in both, planned and imminent and any potential transfers out. • Ensure safe care is accurate and up to date (staffing and acuity) • Assess staffing for the next 48 hours and action any shortfalls (escalate to band 7 senior sister or bleep holder if not present if shortfalls cannot be resolved) • Be able to identify safeguarding patients, acutely unwell patients, challenging behaviour patients and patients with elevated PEWS • Be able to identify admissions, planned discharges and any delays to discharge • Complete NIC checklist • Lead nurse led huddle twice daily
AMBER – OPEL 2
• Identify delays to discharge which cannot be resolved at ward level and escalate to bleep holder • Conduct additional nurse led huddles • Consider patients suitable for moving to other areas
RED – OPEL 3
• Take direction from the bleep holder • Identify patients suitable for moving to other areas
BLACK - OPEL 4
• Take direction from the bleep holder

APPENDIX 1I: ACTION CARD

ACTION CARD: SENIOR MANAGEMENT TEAM- in hours (9am – 5pm)

OUT OF HOURS REFER TO SENIOR MANAGEMENT ON CALL

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GRREN
• Business as usual
AMBER
• Address complex/ delayed discharges
RED
• Link with trust operations team to discuss position and plan/ actions • Review elective/day case and outpatient activity • Review extra nursing capacity to open additional beds
BLACK
• Inform divisional director/ divisional nurse director of situation and plans • Consider additional nursing capacity to open extra bed base • Escalate discussion with divisional/ trust management regarding possible CED divert • Consider cancelling elective/ day and outpatient case activity

APPENDIX 1J: ACTION CARD

ACTION CARD: SERVICE WEEK/RESIDENT PAEDIATRIC CONSULTANT

CHILDRENS IN PATIENT WARDS

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

Children's Service need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff aroundto meet demand taking into account acuity in each area. You will need to be prepared to stay on siteto support the wards and CED or be available to be on site at short notice.

GREEN
• Business as usual
AMBER
• Business as usual
RED -
• Complete additional ward round/ review of potential discharges • Consider transfer of patients across site • Consider elective admissions – are they any suitable for delay? • Liaise with appropriate teams to facilitate discharge and escalate barriers to the SMT • Link with service week consultant at opposite site
BLACK
• Be prepared to stay on site to support paediatric wards, CED and PAU • Escalate discussion with senior management regarding possible CED/ ED divert

APPENDIX 1K: NEONATAL ACTION CARD CO-ORDINATOR/ NURSE IN CHARGE

ACTION CARD:

NURSE IN CHARGE NICU/ NNU

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

GREEN- OPEN TO NETWORK ADMISSIONS
No identified cot/ staffing pressures • Review of babies for discharge • Review of babies to transfer back to post-natal ward • Repatriate any outlying babies • Accept referrals from other hospitals- in line with agreed pathways (with discussion with the medical team) • Ensure staffing levels are as per establishment for the next 24-48hours
AMBER- OPEN TO DERBY AND BURTON ADMISSIONS BETWEEN BOTH SITES
Pressures identified with cots/ staffing and acuity as per staffing ratio calculation on page 10 • actions as above • repatriate babies back to own units if clinically well (with discussion with the medical team) • daily call from centre- inform them we are not accepting outside admissions
RED – OPEN TO LOCAL SITE EMERGENCY ADMISSIONS ONLY
Identify emergency space i.e. 1 space in intensive care and 1 emergency stabilisation space as per nurse staffing calculator p10 • Actions as above • Discuss with consultant expectant pre-term mother who could be transferred out • In hours notify senior midwife on maternity unit phone or out of hours midwifery manager on call, consider any perinatal mothers with a potential to deliver. • Notify the paediatric bleep holder - ask if any staff/ available • Contact own nursing staff/ send text to ask if anyone can do shift/ part of shift. • Contact nurse bank and request escalation accordingly, offer additional hours to senior sisters. • Complete Datix within 24 hours • Consider transferring patients, (between sites/ paediatric ward(s)/ PNW) following liaison/agreement with on service week/ on call consultant/ paediatric bleep holder
BLACK
1 Emergency stabilisation/resuscitation space only • Actions as indicated above • Nurse in charge and consultant neonatologist to liaise face to face during working hours and telephone consultation during out of hours with obstetric consultant and co-ordinator for labour ward (they will then follow their process for closing maternity services if applicable) • Repatriate babies back to own units if clinically well • PNW ward co-ordinator- to identify any preterm mothers who could be transferred out • Complete Datix within 24 hours • Complete black status/shift leader communication record (1 for each shift)

APPENDIX 1L: NEONATAL ACTION CARD CONSULTANT

ACTION CARD: **CONSULTANT NEONTAL SERVICES**

NEONATAL SERVICES

PAEDIATRIC BUSINESS UNIT

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto next level.

As a Children's hospital, we need to be mindful to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff around to meet demand taking into account acuity in each area. You will need to be prepared to stay on site to support the wards and CED or be available to be on site at short notice.

GREEN- OPEN TO NETWORK ADMISSIONS
No identified bed pressures • Business as usual • To be aware of the cots across the both Derby and Burton Neonatal units • Liaise with LW/ obstetric team to utilise cot availability across both units
AMBER- OPEN TO DERBY AND BURTON ADMISSIONS
Pressures identified with staffing/beds and acuity as per shift calculator • Business as usual • To be aware of the cots across the service in both Derby and Burton Neonatal unit
RED – OPEN TO LOCAL SITE EMERGENCY ADMISSIONS ONLY
1 ITU/ HDU i.e. 1 space in intensive care and 1 emergency stabilisation space • Review of potential discharges/ transfers • Transfer suitable babies between sites to maximise cot capacity. • Consultant and consultant obstetrician – to identify preterm mothers who could be transferred out
BLACK
1 Emergency stabilisation space • Be prepared to stay on site to support Neonatal Unit or be available to be on site at short notice. • Neonatal consultant to be informed and aware that there is, the potential to close maternity services to further admissions, this decision must be discussed with Chief operating officer (or deputy)/ Executive on call (or deputy) available through the ops/flow team who can be reached via switchboard.

APPENDIX 1M: Medical fit Patient in delay

ACTION CARD: SMT Lead

This action card summarises actions that you are required to undertake according to the trustemergency pressures escalation policy. It highlights actions to be undertaken in addition to normal duties. Please refer to the policy for a full explanation of levels and actions. All actions for any previous levels must be taken before moving onto the next level.

Children's Services need to be mindful that we may need to support other areas across Children's and optimise medical and nursing staff where appropriate. Examples might be as the consultant on call you need to support other areas as necessary or as bleep holder you will need to move staff around to meet demand taking into account acuity in each area. You will need to be prepared to stay on site to support the wards and CED or be available to be on site at short notice.

RDH

GREEN OPEL 1
• No action required
AMBER- OPEL 2
• Notify service week Consultant • Identify obstacles to discharge and ensure escalation with appropriate organisational leads to progress, detail to be capture on delay to discharge spreadsheet • Ensure safeguarding aware of individual cases of delay • Ensure PBS Risk assessments in place and appropriate staffing ratio
RED- OPEL 3
• Assume all points above already in action • PBS member to attend board round • Divisional Director, Divisional nurse Director of OPEL 3 status • Ensure Risk assessments in place and appropriate staffing ratio • Notify Senior commissioning manager for mental health • Notify CAMHS Service leads, Social Care, • Complete Datix if child remains in CED (as per Flow chart on page 8)
BLACK- OPEL 4
• Decision to admit/hold in CED needs to be between service week Consultant, CED consultant, SMT/Manager on call. • Notify Divisional Director, Divisional nurse Director and Executives of OPEL 4 status • Submit IR1 via Datix relating to black escalation system pressure • Further notification to Directors of CCG, DHFT, Social Care, Director of social care if Out of area.

QHB

GREEN OPEL 1
• No action required
AMBER- OPEL 2
RED- OPEL 3
BLACK- OPEL 4
• Notify Service week consultant • Identify obstacles to discharge and ensure escalation with appropriate organisational leads to progress, detail to be capture on delay to discharge spreadsheet

- Ensure safeguarding aware of individual cases of delay
- Ensure PBS Risk assessments in place and appropriate staffing ratio
- PBS member to discuss with service consultant post ward review
- Represent UHDB at minimum of twice weekly meetings with relevant
- Notify Divisional Director, Divisional nurse Director and Executives of OPEL 4 status
- Submit IR1 via Datix relating to black escalation system pressure
- Further notification to Directors of CCG, DHFT, Social Care, Director of social care if Out of area.