POLICY DOCUMENT

Burton Hospitals
NHS Foundation Trust

PAEDIATRIC RESPITE & DIVERT POLICY

Approved by:	**Trust Executive Committee**
On:	**28 November 2017**
Review Date:	**Sep 2020 EXTENDED DEC 2020**
Corporate / Directorate	**Directorate**
Clinical / Non Clinical	**Clinical**
Department Responsible for Review:	**Paediatrics**
Distribution:	
˅ Essential Reading for:	**Executives** **Operational Managers** **On Call Managers** **Head Nurses and Matrons** **Clinical Site Practitioners** **Duty Sisters** **Paediatric Medical Staff** **Paediatric Nursing Staff**
˅ Information for:	**ED Department** **All Medical Staff**
Policy Number:	**188**
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Date:	**28 November 2017**

Burton Hospitals NHS Foundation Trust

Policy Index Sheet

Title:	**Paediatric Respite and Divert Policy**
Original Issue Date:	**July 2007**
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Reason for amendment:	**Routine Review & Update as required**
Responsibility:	**Paediatric Matron**
Stored:	**Paediatric Policies – Intranet Site**
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Consulted	**Executives** **Operational Managers** **On Call Managers** **Head Nurses and Matrons** **Clinical Site Practitioners** **Duty Sisters** **Paediatric Consultants** **Paediatric Senior Nurses** **ED Consultants** **ED Senior Nurses**

REVIEW AND AMENDMENT LOG

Version	Type of Change	Date	Description of Change
1	New policy	July 2007	
2	Review	July 2011	
3	Review	November 2014	
4	Full review and update	October 2017	New procedures

PAEDIATRIC RESPITE & DIVERT POLICY

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Burton Hospitals NHS Foundation Trust

PAEDIATRIC RESPITE & DIVERT POLICY

1. Introduction

The paediatric unit is made up of Ward 1 (11 beds), Ward 2 (8 beds) and the Paediatric Assessment Unit – PAU (6 beds). There are 25 beds/cots in total which are managed flexibly depending on speciality demand and patient need.

This Policy sets out how Paediatric Bed Capacity should be managed.

The Paediatric wards need to work closely with the Bed Management Team so that they have an awareness of the current level of working at all times.
In order to ensure that the Paediatric Department maximises the use of its available beds it should be remembered that:

- Children/young people, (aged 0 to 18 years) should only be admitted when their needs cannot be appropriately met at home with their families (with/without the support of the Children's Community Nursing Team as required).

- All children and young people should have a comprehensive assessment of their health and care needs within 4 hours of their admission to the ward.

- Discharge planning should begin at the decision to admit, wherever that decision is made.

- Discharge planning procedures must show due regard to individual choice, cultural characteristics, personal dignity and safety.

- The Child/Young Person and the family/carers must be involved in all stages of the process.

As Paediatrics have a short length of stay and have a significant number of patients admitted for less than 24 hours, changes in bed occupancy and dependency within the unit can occur very quickly GP referrals to Paediatrics are seen in the PAU which is open 24 hours 7 days a week.

Paediatric ward staff have clinical knowledge of when patients will be discharged and an understanding of the approximate timeframe for discharge. The Paediatric Unit has 25 funded beds. Bed occupancy should not exceed 24 day or night. If there are 25 patients and no **anticipated discharges** the Escalation Process described below needs to be followed.

Due to these rapid changes in bed occupancy/dependency the Nurse in charge is required to constantly assess the unit with reference to current and predicted bed availability communicating this information to the Paediatric Matron who will liaise with the Bed Management Team – Daytime, Duty Sister / Clinical Site Practitioner – Out of hours. When occupancy starts to increase the Escalation

Process (see Appendix 3) will be followed by the unit. This is supported by action cards detailing individual's responsibility for the processes.

2. Escalation Process

A three stage Escalation Process is used to determine action required in relation to the bed/cot occupancy on the Paediatric Wards (refer to Appendix 3).

Level One – normal position

1. Beds available on paediatric unit for planned and emergency admissions.
2. No current risk of a child/young person waiting more than 4 hours to be seen in ED
3. Elective work proceeding as planned

Action – Nil required at present

Level Two - Moderate Pressures

1. Beds available on paediatric unit for planned and emergency admissions but if admitted will reach capacity of the Unit.
2. Children currently for assessment in PAU and ED where there is an expectation of admission that will take the Ward over capacity
3. No confirmed discharges within next 2 hours on the Ward.

Actions –

1. Paediatric Registrar to review all children and young people in paediatric triage and ED

2. Paediatric Registrar or Consultant to conduct an extra ward round on the children's ward in order to review all inpatients with a view for possible discharge.

3. Consider postponing elective admissions until more beds available

4. Assess if any 16 or 17 year old patients can be transferred to an adult ward depending on condition and bed availability

Level Three – Severe Pressures

Paediatric unit full to capacity – predicted discharges within a 4 hour period but not within the next 2 hours

Actions –

1. Consult managers to inform of the situation and ask if the paediatric unit can enter a period of RESPITE for a maximum of 4 hours.

2. All areas involved informed as in Policy.

3. GPs to send children to ED not PAU.

4. Review and cancel elective admissions

Level Four – Extreme Pressures

1. Paediatric unit full to capacity – No predicted discharges in the next 4 hours

2. Paediatric unit already on respite

Actions -

Consult managers to inform of the situation and ask if the paediatric unit can goon DIVERT

- All areas involved informed as detailed on the Action Cards (Appendix 4).
- Admissions are then **"diverted"** to other health care providers until the situation improves and admissions can once again be accepted within the defined time scale

3. Respite

3.1 Definition of Respite

Respite allows the ward to safely manage their inpatients, discharge and free up beds while not accepting any admissions whether they are elective, non-elective or day cases either private or NHS. The Nurse in Charge will assess child dependency/volume and determine if it is safe to support ED with any Paediatric emergency calls during this time.

Respite is put into action for a stated period of time – (**no longer than 4 hours)** when the unit has reached Stage Two in the Escalation Process and there are 24 patients on the ward and no predicted discharges in the next 2 hours but there are predicted discharges within a 4 hour period (within the **respite** period). Therefore discharges or transfers will have occurred before the end of the **respite** period giving rise to empty beds within the unit and less than 24 in-patients.

Only go on **respite** if it is likely that there will be beds available after 4 hours or that the unit would be safe within that period of time. If there is no possibility of beds being vacated or the unit being made safe then **divert** must be considered.

If a period of **respite** is required – the Nurse in Charge of the Paediatric Unit must follow the plan as below before the **respite** can be declared.

During a period of **respite** the protocol below is followed.

As the Ward and PAU will be filled to capacity, all GP admissions are directed to ED with Paediatric Doctors from the Ward seeing the referrals in the Emergency Department, assessing and either discharging home, transferring out if immediate care is required or making a decision to admit once **respite** has come to an end. This will mean that a child that requires admission will need to wait in ED until such time as a bed becomes free for them. Any child requiring transfer from the Emergency Department will require an escort from ED as this cannot be supported through the ward at this time.

3.2 Protocol for Establishing a Period of Respite on the Paediatric Wards - Level 3 Escalation

3.2.1 Inform the Service week/On Call Paediatrician (Registrar On call out of hours) to come to do a ward round as a period of **respite** may be required. Prior anticipation of this is useful.

3.2.2 Nurse in Charge will assist Paediatric Medical Staff to re-assess the in-patients with another ward round with a view to identifying further patients for discharge.

3.2.3 If there are no immediate discharges, but patients have been identified who can be discharged within the following 4 hours - then the situation remains that the unit is required to go on **respite**.

3.2.4 The Paediatric Matron / Duty Sister / CSP will contact the Head Nurse / Manager on Call and initiate respite. If due to their workload this is not possible the Manager on Call should be available to support the process but this would be an unusual occurrence.

3.2.5 The Paediatric Matron / Duty Sister / CSP will inform the Head Nurse / Manager on call of the actions being taken and that the action cards and Policy have been followed.

3.2.6 The Paediatric Matron / Duty Sister / CSP will then liaise with the Nurse in Charge of ED informing them of the situation and that for a stated period of time all GP referrals will be sent directly to them; they will be advised that they should bleep a Paediatric Doctor on their arrival in order to keep the pathway moving.

3.2.7 The Paediatric Matron / Duty Sister / CSP will need to ensure the following are all aware of the need for a Paediatric Respite – (for contact numbers see Appendix 2):-

- All Paediatric Consultants - in the daytime (they review their own patients)
- On-Call Paediatric Consultant - if at weekend or night
- Switchboard
- Doctors taking GP calls for:
  - Paediatrics
  - ENT
  - Orthopaedic
  - Ophthalmology
  - Surgery

NOTE: These Doctors need to be informed to tell the referring GP that due to high bed usage there are no beds available at present - they can still send the child to ED to be seen there or if they wish they can send them to another hospital of their choice.

During a period of respite Doctors cannot refuse to accept patients.

3.2.8 The Nurse in Charge is required to give relevant feedback on the current bed state/occupancy/dependency to the Paediatric Matron – Daytime, Duty Sister/CSP out of hours who will then update Bed Management during the period of **respite.**

NO patients will be admitted when on a period of respite

4. Divert

4.1 Definition of Divert

Divert is **only** requested when all other options have been considered and when **respite** cannot be used – either because the ward has already been on **respite** for 4 hours and there is no further planned movement (discharges/transfers) for the next 4 hours plus or that no movement was identified while looking at the possibility for **respite** till after a 4 hour period. (This is usually the case late evening or in the night). In which case level four of the Escalation Process has been reached.

Therefore if no movement is possible - then **divert** of admissions should be performed and not **respite.**

If a period of **divert** is required – the Nurse in charge of the Paediatric Unit must follow the plan as below before **divert** can be declared.

During a period of **divert** the protocol below is followed, no admissions are accepted to the Wards or ED from GPs. ED will continue to take any self referrals and when necessary refer to the Paediatric Registrar on call for assessment who will either discharge them home or arrange transfer with ED if immediate care is required.

4.2 Protocol for Establishing a Period of Divert on the Paediatric Wards

4.2.1 Inform the Service Week/On call Paediatrician (Paediatric Registrar Out of hours) to come to do a ward round as a period of **divert may be required** – if potential discharges can be identified it may be that divert is avoided and a period of **respite** will suffice.

4.2.2 Assist the Paediatric Medical Staff to re-assess the in-patients with another ward round with a view to identifying further patients for discharge.

4.2.3 If there are no immediate discharges and no patients identified that will be discharged within the following 4 hours - then the situation still remains that the unit may be required to move to divert. The Paediatric Matron / Duty Sister / CSP will liaise with the Head Nurse / Operational Manager that divert is necessary who in turn will inform the Executive.

4.2.4 If divert is needed the Paediatric Matron/senior sister (in hours) or the Duty Sister / Clinical Site Practitioner (out of hours) will inform the relevant authorities.

In hours, the Paediatric Matron/senior sister will liaise with the Ops Room and manager. The Regional Capacity Management Team (RCMT) will be informed on 0121 612 1727 to ascertain local paediatric bed availability and liaise with West Midlands Ambulance Service (WMAS) on 0121 307 9119.

Out of hours, the Duty sister (until 2000) and the Clinical Site Practitioner (CSP) from 20.00-08.00 will liaise with manager/executive on call. Once divert has been agreed the RCMT will be contacted on 07766922556 and WMAS on 0121 307 9119.
The **Hospital Executive on call** who will then liaise with the **Executive on call at the receiving hospital** that it is being requested to accept 999 diverts from our area.

This can be difficult in Paediatrics as often there are only 1 or 2 beds available at each hospital – so more than 1 hospital may be needed for successive diverts in a night for 999 calls.

The Executive MUST establish that WMAS will inform EMAS. If not EMAS MUST be contacted via the EMAS Control. NOTE The Ops Room / Duty Sister / CSP will need to inform the **Out of Hours GP services** where Paediatric beds are available for their referrals. **(See Appendix 1 for telephone numbers)**

4.2.5 ED (including Consultant) will be informed of the situation and that Paediatric 999 calls will be diverted to other hospitals. The Paediatric Matron/Ops Room (in hours) or Duty Sister / CSP (out of hours) must ensure that the following are all aware of the Paediatric **divert** situation: - (contact details on last page).

- Paediatric Consultant on call as well as Service Week Consultant.
- Switchboard.
- Local Hospitals.
- Doctors taking GP calls for:-
    - Paediatrics
    - ENT
    - Orthopaedic
    - Ophthalmology
    - Surgery

All Doctors need to be informed that they should tell referring GP's that due to high bed usage there are no beds available and that the unit is diverting admissions. **During divert Paediatric Doctors can refuse to accept patients** and will need to advise the GP of where there are beds for them to be able to choose where they wish to refer the child to. This information will be given to each speciality by the Paediatric Matron / Duty Sister / CSP who gained the information regarding bed availability.

NO patients will be admitted when on divert.

In the extreme when divert is not an option due to other hospitals being at full capacity, a local contingency plan should be followed:

All patients aged 16 years and above are to be assessed for the suitability of possible transfer to an adult ward if beds are available. It should be determined if unopened beds can be opened utilising current staff or if staff from the neonatal area are available to support the process. A risk assessment should be completed on the ward balancing the needs of the children admitted and increased capacity.

5. Elective Patients

In rare cases of **divert** when there is no possibility of discharges, elective patients will have to be cancelled. Although every effort will be made to give children/Young People and their Parents/carers sufficient notice prior to cancellation of an elective surgical procedure, it could be on the day of admission. In hours this will be done by the Paediatric Matron or Senior ward staff and out of hours by a Senior nurse on the Paediatric unit with assistance from Bed Management / CSP. If possible an early phone call to warn parents of the possibility of cancellation due to bed occupancy can be made by the nurse in charge recommending that fasting should continue until confirmation of the cancellation is obtained.

6. Home Leave Patients

There are patients who may be on Home Leave when a need to move to respite or divert arises.

Patients on Home Leave during these times need to be reprioritised and if they can have their return delayed without comprising patient safety or care, then efforts should be made to contact the Carers to discuss delaying their return allowing the bed to be utilised.

7. In all Cases of Respite or Divert

7.1 In all cases of **respite** or **divert** continued good levels of communication must be continued with all staff and departments – especially Bed Management and ED as Paediatric **respite** or **divert** can impact on ED's performance and adult pathways if not managed effectively and efficiently.

7.2 If ED cannot cope with **respite** in their department then the Matron will be informed and **divert** will be instigated due to ED requirements rather than Paediatrics.

7.3 Staff must log the times of start and stop of the period of **respite** or **divert** (on checklist – Appendix 2) and note who has been informed at each stage.

7.4 Ward Staff/ED staff must log all children transferred or diverted to other hospitals during a period of **respite or divert.**

7.5 At the end of the period of **respite or divert** – all the above people and areas must be informed by Matron / Bed Management / CSP that the ward has either ceased to be on **respite** or that the ward has **"re-opened**" following **divert.**

7.6 By using the check list at the back of the Policy this would enable someone else to take over with a full understanding of the situation and position in the **respite or divert** process.

7.7 Please forward the completed check list to Paediatric Matron if divert is at night or weekends when a Paediatric Matron is not on duty.

8. Latest Time which a Respite Period may be requested

If a respite period is requested, it is done so in order to allow time for patients to be reviewed so that any patients who are well enough to go home can do so, thus releasing beds to allow for new admissions.

The latest time a respite period should be called is 9pm to allow for any discharges to be completed prior to 10pm., calling a respite period later than 10pm may compromise patient safety and/or quality of the discharge.

APPENDIX 1 – Contact Numbers

Contact Numbers - For when ward going on to **respite** or on **divert:**

Paediatric Consultants' Secretaries – via switchboard if nights/weekends:

Dr Ahmed	ext 4360
Dr Choules	ext 4367
Dr Goel	ext 4368/4367
Dr Manzoor	ext 4360
Dr Muogbo	ext 4199
Dr Yarlagadda	ext 4638

Switchboard: 0

On Call Manager and On Call Executive – via switchboard

Emergency Department:

ED Matron	ext 5652, bleep 475
ED Consultant secretaries	ext 5479
ED Nursing Station	ext 5001
ED Minors	ext 5026
ED Receptionists	ext 5004

Bleep Numbers for Doctors taking GP calls for:-

- Paediatrics Bleep - 512
- ENT Bleep - via switch on call changes daily
- Orthopaedic Bleep - 471
- Ophthalmic Daytime -16.00hrs call Eye Clinic ext 5085.
- Surgery Bleep - 495

Bed Management - 07.00 – 21.30hrs Bleep 258 Ext 5464

Clinical Site Practitioners - 21.00 - 07.00hrs Bleep 581

Regional Capacity Team –
Weekdays (0121 612 172) In the day time the Bed Capacity Manager will contact this team.
Out of Hours – 07766 922556

West Midlands Ambulance Service (WWAS) – 0121 307 9119

This is West Midlands Ambulance only – must ask if they have informed East Midlands Ambulance Service.

If not contact EMAS on: #6204

Telephone numbers of Local Hospitals
(Information should be given by the Regional Capacity team – they will know Staffordshire but they will need to contact Derbyshire/Nottinghamshire/Leicestershire).

- Good Hope - # 6114 0121 4242000
- Stafford - # 6134 01785 257731
- Derby Royal - # 6110 01332 340131

- Leicester Royal - # 6118 0116 2541414
- Heartlands - # 6166 0121 4242000
- George Elliot - # 6113 02476 351351
- Walsall Manor - # 6122 01922 721172
- BCH – B'ham child - # 6108 0121 3339999

Out of Hours GP Care

Staffordshire Doctors Urgent Care (SDUC)	03001237769
Derbyshire Health United	08444122235
Leicestershire and Rutland Out of Hours	08450450411

APPENDIX 2 - Checklist

For Period of: RESPITE / DIVERT - (circle action taken)

Respite or Divert inform:-
MANAGER ON CALL – NAME…….TIME……

If Divert also need to inform:-
EXECUTIVE ON CALL – NAME……..TIME…….

REASON FOR RESPITE/DIVERT – (number of patients – dependency levels – staffing)

Check list – who to inform and information	**Start of respite/divert**		**End of respite/divert**	
DATE:-	TIME:-		TIME:-	
Number of Patients	Start number=		End number=	
	Time informed	**Contact/Name of person informed**	**Time informed**	**Contact/Name of person informed**
Paediatric Consultants – all in the daytime Paediatric Consultant On Call evenings/ nights and weekends				
Paediatric Matron 8am-4pm 4671 Bleep 354				
Duty Sister 4pm-8pm Bleep 369				
Clinical Site Practitioner 8pm-8am Bleep 581				
Bed Manager 5456 Bleep 258				
Emergency Dept				
ED Consultant Secretaries 5479				
ED Matron 5652 Bleep 475				
ED Reception 5004				
ED Minors 5026				
ED Nurses Station 5001				

Drs on Call for GP admissions:-					
Paediatrics Bleep 512					
ENT Bleep via switch, differs each day					
Orthopaedic Bleep 471					
Ophthalmology 8am-4pm 5085 4pm-8am 4071					
Surgery Bleep 495					
If divert also inform and contact:-	**Time informed**	**Contact/Name of person informed** **START**		**Time informed**	**Contact/Name of person informed** **END**
Regional Capacity Team 8am-4.30pm 0121 612 1727 Out of hours – 07766 922556					
All Ambulance services for divert					
WMAS 4.30pm-8am weekdays, all weekend and Bank Holidays 0121 307 9119					
EMAS informed? #6204					
All GP Out of Hours services for divert					
Staffordshire Doctors Urgent Care (SDUC) 0300 123 7769.					
Leicestershire 08450450411					
Derbyshire Health United 08444122235					
Local Hospitals Cot/bed status, at given time	Contact Name / Bleep	Time	No of BEDS	No of COTS	Comments
Good Hope #6114 0121 4242000					
Stafford #6134 01785 257731					

Derby Royal #6110 01332 340131					
Leicester Royal #6118 0116 2541414					
Stoke (North Staffs) #6136 01782 552745					
Heartlands #6166 0121 424000					
George Elliot #6113 02476 351351					
Walsall Manor #6122 01922 721172					
Birmingham Childrens #6108 0121 3339999					

Appendix 3 Paediatric Bed Management Escalation Process

Level 1	Level 2	Level 3	Level 4
Management – Nurse in charge of paediatric ward	**Management – Paediatric senior sister/paediatric matron**	**Paediatric Matron/senior sister Bed Manager Operational Manager Associate Director**	**Paediatric Matron Bed Manager Service Manager Associate Director Executive**
1. No current risk of a child/young person waiting more than 4 hours to be seen in ED.	1. Beds available on paediatric unit for planned and emergency admissions but if admitted will reach capacity of unit	1. Paediatric unit full to capacity, level 2 actions complete	1. Paediatric unit full to capacity – No predicted discharges in the next 4 hours
2. Beds available on the paediatric unit for planned and emergency admissions	2. Children currently for assessment in PAUand ED where there is an expectation of admission that will take the unit over capacity	2. Predicted discharges within a 4 hour period but not within the next 2 hours	2. Paediatric unit already on respite
3. Elective work proceeding as planned	3. No confirmed Discharges within next 2 Hours on the Unit		
Action – nil required	**Actions - Paediatric Registrar to review all patients in PAU and ED Paediatric Registrar or Consultant to conduct an extra ward round on the children's ward in order to review all inpatients with a view for possible discharge. Consider postponing elective admissions until more beds available Assess if any 16 or 17 year old patients can be transferred to an adult ward depending on condition and bed availability**	**Actions - Consult managers to inform of the situation and ask if the paediatric unit can enter a period of RESPITE for a maximum of 4 hours. All areas involved informed as in Policy. GPs to send children to ED not PAU. Review and cancel elective admissions**	**Actions - Consult managers to inform of the situation and ask if the paediatric unit can go on DIVERT**

Step by Step Activation of Respite
Day Time 8am to 8pm Weekdays

Role of the Paediatric Nurse in Charge

1. Will assess dependency and acuity of existing patients and review patient allocation. Process to be repeated throughout the shift as children are admitted / discharged or as acuity changes.
2. Will collate information related to number(s) of ED and GP referrals the Ward/Paediatric Triage are expecting.
3. Will determine the safety of the patients on the unit utilising all 24 beds with the existing staffing levels – if assistance is required, extra staff will be requested.
4. Will determine if any adolescents (16-18 years old) are able to be transferred to an adult facility. If appropriate, and beds are available, the adolescent should be transferred to free up Paediatric beds.
5. Will ensure that a Consultant / Registrar is able to complete a ward round and determine the potential discharges establishing where possible markers that can be used to facilitate nurse led discharge.
6. Will ensure that the Paediatric team on duty are available to review children in ED as a result of divert if required.
7. Will ensure the Paediatric Matron / Duty Sister is aware of the current situation to enable them to initiate their processes.
8. Will give regular updates on the current bed state, occupancy and dependency to the Paediatric Matron / Duty Sister.

Role of the Paediatric Matron 8am-5pm / Duty Sister 5pm-8pm

1. The Paediatric Matron / Duty Sister will be informed by the Nurse in Charge of the need to go onto on respite using the Escalation Procedure.
2. If more staff are required, the Paediatric Matron / Duty Sister will delegate the responsibility for calling staff to an appropriate member of the team (Ward Clerk/HCA).
3. The Paediatric Matron / Duty Sister will inform the Head Nurse / Operational Manager that all processes have been followed and respite is required.
4. The Paediatric Matron / Duty Sister will inform:
    1) Out of Hours GP services of where to refer patients
    2) Emergency Department
    3) Switchboard
    4) Doctors taking GP calls for – Paediatrics, ENT, Orthopaedics, Surgery and Ophthalmology
5. The Paediatric Matron / Duty Sister will complete the Checklist and will be responsible for documenting all action taken.
6. The Paediatric Matron / Duty Sister will give regular updates on the current bed state, occupancy and dependency to the Head Nurse / Operational Manager.

Role of the Head Nurse / Operational Manager

1. The Paediatric Matron / Duty Sister will inform the Head Nurse / Operational Manager of the need for respite and that all processes have been followed.
2. The Head Nurse / Operational Manager will keep up to date with the present situation and consider the need to go onto divert using the Escalation Procedure.
3. The Head Nurse / Operational Manager will contact the Executive to update them on the present situation and the impending need for Escalation to Divert.

Step by Step Activation of Divert
Day Time 8am to 8pm Weekdays

Role of the Paediatric Nurse in Charge

1. Will assess dependency and acuity of existing patients and review patient allocation. Process to be repeated throughout the shift as children are admitted / discharged or as acuity changes.
2. Will collate information related to number(s) of ED and GP referrals the Ward / PAUare expecting.
3. Will determine the safety of the patients on the unit utilising all 24 beds with the existing staffing levels – if assistance is required, extra staff will be requested.
4. Will determine if any adolescents (16-18 years old) are able to be transferred to an adult facility. If appropriate and beds are available the adolescent should be transferred to free up Paediatric beds.
5. Will ensure that a Consultant / Registrar is able to complete a ward round and determine the potential discharges establishing where possible markers that can be used to facilitate nurse led discharge.
6. Will ensure that the Paediatric team on duty are available to review children in ED as a result of divert if required.
7. Will ensure the Paediatric Matron / Duty Sister are aware of the current situation to enable them to initiate their processes.
8. Will give regular updates on the current bed state, occupancy and dependency to the Paediatric Matron / Duty Sister.

Role of the Paediatric Matron 8am-5pm / Duty Sister 5pm-8pm

1. The Paediatric Matron/Duty Sister will be informed by the Nurse in Charge of the need to go on divert using the Escalation Procedure.
2. If more staff are required, the Paediatric Matron / Duty Sister will delegate the responsibility for calling staff to an appropriate member of the team (Ward Clerk/HCA).
3. The Paediatric Matron / Duty Sister will inform the Head Nurse / Operational manager that all processes have been followed.
4. The Paediatric Matron / Duty Sister will inform:
    1) Out of Hours GP services of where to refer patients
    2) Emergency Department
    3) Switchboard
    4) Doctors taking GP calls for – Paediatrics, ENT, Orthopaedics, Surgery and Ophthalmology
5. The Paediatric Matron / Duty Sister will contact the Capacity Team for Staffordshire (8am-4.30pm) OR WMAS (4.30pm-8am) to identify other units with beds.
6. The Paediatric Matron/Duty Sister will give regular updates on the current bed state, occupancy and dependency to the Head Nurse / Operational Manager.
7. The Paediatric Matron / Duty Sister will complete the Checklist and will be responsible for all actions taken.

Role of the Head Nurse / Operational Manager

1. The Paediatric Matron / Duty Sister will inform the Head Nurse / Operational Manager of the need for divert and that all processes have been followed.
2. The Head Nurse / Operational Manager will inform the Executive of the need for divert, the actions taken, where there are beds available and the PCT's Executive's mobile number.
3. The Head Nurse / Operational Manager will give regular updates on the current bed state, occupancy and dependency to the Executive.

Role of the Executive

1. The Executive will contact the Units to agree divert(s).
2. The Executive will contact WMAS to confirm divert(s) asking if EMAS have been informed.
3. The Executive will contact EMAS if WMAS have not already done so.
4. The Executive will contact the PCT's Executive.

Step by Step Activation of Respite
Night Time 8pm to 8am and Weekends

Role of the Paediatric Nurse in Charge

1. Will assess dependency and acuity of existing patients and review patient allocation. Process to be repeated throughout the shift as children are admitted / discharged or as acuity changes.
2. Will collate information related to number(s) of ED and GP referrals the Ward/PAU are expecting.
3. Will determine the safety of the patients on the unit utilising all 24 beds with the existing staffing levels – if assistance is required, extra staff will be requested.
4. Will determine if any adolescents (16-18 years old) are able to be transferred to an adult facility. If appropriate and beds are available the adolescent should be transferred to free up Paediatric beds.
5. Will ensure that a Consultant / Registrar is able to complete a ward round and determine the potential discharges establishing where possible markers that can be used to facilitate nurse led discharge.
6. Will ensure that the Paediatric team on duty are available to review children in ED as a result of divert if required.
7. Will ensure the CSP's are aware of the current situation to enable them initiate their processes.
8. Will give regular updates on the current bed state, occupancy and dependency to the CSP's.

Role of the Clinical Site Practitioner

1. The CSP will be informed, by the Nurse in Charge, of the need to go on respite using the Escalation Procedure.
2. If more staff are required, the CSP will delegate the responsibility for calling staff to an appropriate member of the team (Ward Clerk/HCA).
3. The CSP will inform the On Call Manager that all processes have been followed.
4. The CSP will inform:
    1) Out of Hours GP services of where to refer patients.
    2) Emergency Department.
    3) Switchboard.
    4) Doctors taking GP calls for – Paediatrics, ENT, Orthopaedics, Surgery and Ophthalmology.
5. The CSP will complete the Checklist and will be responsible for documenting all action taken.
6. The CSP will give regular updates on the current bed state, occupancy and dependency to the On Call Manager.

Role of the On Call Manager

1. The CSP will inform the On Call Manager of the need for respite and that all processes have been followed.
2. The On Call Manager will keep up to date with the present situation and consider the need to go onto divert using the Escalation Procedure.
3. The On Call Manager will contact the On Call Executive to update them on the present situation and the impending need for Escalation to Divert

Step by Step Activation of Divert
Night Time 8pm to 8am and Weekends

Role of the Paediatric Nurse in Charge

1. Will assess dependency and acuity of existing patients and review patient allocation. Process to be repeated throughout the shift as children are admitted / discharged or as acuity changes.
2. Will collate information related to number(s) of ED and GP referrals the Ward/Paediatric Triage are expecting.
3. Will determine the safety of the patients on the unit utilising all 24 beds with the existing staffing levels – if assistance is required, extra staff will be requested.
4. Will determine if any adolescents (16-18 years old) are able to be transferred to an adult facility. If appropriate and beds are available the adolescent should be transferred to free up Paediatric beds.
5. Will ensure that a Consultant / Registrar is able to complete a ward round and determine the potential discharges establishing where possible markers that can be used to facilitate nurse led discharge.
6. Will ensure that the Paediatric team on duty are available to review children in ED as a result of divert if required.
7. Will ensure the CSP is aware of the current situation to enable them initiate their processes.
8. Will give regular updates on the current bed state, occupancy and dependency to the CSP.

Role of the Clinical Site Practitioner

1. CSP will be informed by the Nurse in Charge of the need to go on divert using the Escalation Procedure.
2. If more staff are required, the CSP will delegate the responsibility for calling staff to an appropriate member of the team (Ward Clerk/HCA).
3. The CSP will inform the On Call Manager that all processes have been followed.
4. The CSP will inform:
    1) Out of Hours GP services of where to refer patients
    2) Emergency Department
    3) Switchboard
    4) Doctors taking GP calls for – Paediatrics, ENT, Orthopaedics, Surgery and Opthalmology
5. The CSP will contact WMAS to identify other units with beds and obtain the PCT's On Call Executive's mobile number to give to the On Call Manager.
6. The CSP will give regular updates on the current bed state, occupancy and dependency to the On Call Manager.
7. The CSP will complete the Checklist and will be responsible for all actions taken.

Role of the On Call Manager

1. The CSP will inform the On Call Manager of the need for divert and that all processes have been followed.
2. The On Call Manager will inform the Executive of the need for divert, the actions taken, where there are beds available and the PCT's On Call Executive's mobile number.
3. The On Call Manager will give regular updates on the current bed state, occupancy and dependency to the On Call Executive.

Role of the On Call Executive

1. The On Call Executive will contact the Units to agree divert(s)
2. The On Call Executive will contact WMAS to confirm divert(s) asking if EMAS have been informed.
3. The On Call Executive will contact EMAS if WMAS have not already done so.

4. The On Call Executive will contact the PCT’s On Call Executive.