Kettering General Hospital NHS Foundation Trust

Kettering General Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Kettering General Hospital

Requires Improvement 

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of Children and Young Persons (CYP) services at Kettering General Hospital.

During this inspection we inspected 2 core services including CYP and Urgent and Emergency Care (UEC) using our focused inspection methodology. We only inspected the Paediatric Emergency Department (PED). We did not cover all key lines of enquiry; however, we have rated the service in accordance with our enforcement policy.

Our rating for CYP services went down. We rated them as inadequate and have taken enforcement action as a result of this inspection to promote patient safety. We served a Section 29A Warning Notice to the trust requiring them to make improvements in relation to multiple areas including medicines management, risk assessments, identification and treatment of sepsis, fluid balance monitoring, safeguarding processes, learning from serious incidents, and equipment and environment risks. Following our inspection, the service provided us with a comprehensive improvement plan outlining how they intended to address areas of concerns outlined in the warning notice.

During our inspection on 6 and 19 December 2022, we visited the PED, the Paediatric Assessment Unit (PAU), Skylark ward and the neonatal unit.

We spoke to 27 members of staff of all levels including health care assistants, registered nurses, ward managers, matrons, doctors and service leads. We reviewed 27 patient records and other documentation including incident reports, meeting minutes, quality audits and trust policies and procedures.

We spoke to the parents of 9 patients and 2 patients.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Services for children and young people

Inadequate 

Our rating of this service went down. We rated it as inadequate because:

- Not all staff had completed mandatory training including the highest level of life support. Systems to check nationally approved child protection information sharing systems were in not fully embedded. The service did not always control infection risk well. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always complete and update risk assessments for each patient. Risks were not always removed or minimised. Staff did not always effectively identify and quickly act upon patients at risk of deterioration. The service did not have enough nursing staff or medical staff. Records were not stored securely. The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Improvements following lessons learnt were not always fully embedded and sustained.
- Key nursing leadership positions had been vacant which impacted oversight of quality and safety. Staff did not always feel respected, supported and valued. The service did not always have an open culture where patients, their families and staff could raise concerns without fear. Leaders did not always operate effective governance processes. Staff did not always have regular opportunities to meet, discuss and learn from the performance of the service. Leaders and teams did not always use systems to manage performance effectively. Risk assessments to continually identify ward based risks were not always effective. Actions to reduce the impact of risks were not always in place or effective. The service did not always collect reliable data and analyse it. Staff could find the data they needed, but not always in easily accessible formats, to understand performance, make decisions and improvements.

However:

- Staff had training on how to recognise and report abuse and they knew how to apply it. Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Clinical waste was disposed of safely. Processes were in place to safely manage patients requiring a higher level of care. The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised.
- Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable. However, monitoring of the strategy was inconsistent. The service provided opportunities for career development. Staff at all levels were clear about their roles and accountabilities. Leaders identified and escalated relevant risks. They had plans to cope with unexpected events. Data or notifications were consistently submitted to external organisations as required.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training. However, not all staff had completed it.

Services for children and young people

Registered nursing (RN) staff received and kept up to date with their mandatory training. Following our inspection, the service provided us with a breakdown of mandatory training compliance data as of the end of October 2022. RNs working on Skylark ward and the neonatal unit were compliant with the trust 85% target in all 12 modules, ranging from 85 to 100% compliance.

Medical staff received but did not always keep up to date with their mandatory training. Data showed medical staff working across children and young people services were not compliant with 9 out of 14 mandatory training modules. For example, fire safety (81%), infection control (81%), sepsis (81%) and new-born basic life support (67%). Managers told us they had a plan in place to support medical staff with ongoing professional development which included time to complete mandatory training.

Mandatory training was comprehensive and met the needs of children, young people and staff. Training modules included key areas such as: health and safety, fire safety, manual handling, infection prevention and control, equality and diversity, information governance, sepsis and paediatric and new-born basic life support. Training was a combination of face to face and online learning.

Compliance to the highest level of life support training was not achieved for medical or RN staff. During our previous inspection in 2017, we found not all relevant staff were trained to the highest level of paediatric life support. During our recent inspection, we found this had not improved. Data provided to us following the inspection showed 8 out of 12 (67%) consultants and 12 out of 13 (92%) registrars had completed either European Paediatric Advanced Life Support (EPALS) or Advanced Paediatric Life Support (APLS). Furthermore, 100% of registrars and 83% of consultants had completed neonatal life support. Some staff who had not completed these were booked onto training sessions. However, 3 consultants were on a waiting list for EPALS due to a shortage of external training courses.

Data provided by the trust showed 9 out of 33 (45%) RNs had completed EPALS. A further 2 were booked to complete this training in January 2023. Managers told us this enabled at least 1 EPALS trained person on each shift. The service monitored compliance with having an EPALS member of staff on each shift. However, data provided to us following our inspection showed from September to December 2022, the service did not always have an EPALS trained RN on each shift, except for September 2022, where 100% of shifts had an EPALS trained RN on each shift. For example, in October 92% of shifts had an EPALS trained RN available, 98% in November and 95% in December.

Most RNs (90%) on Skylark ward, including the Paediatric Assessment Unit (PAU) had completed Paediatric Immediate Life support (PILS).

Compliance to the highest level of life support in the paediatric assessment unit was not achieved. Data provided by the service following our inspection showed from September to December 2022, an average of 60% of shifts were covered by a staff member with EPALS or APLS. This was not in line with the Royal College of Nursing (RCN) safe staffing guidelines which states a PAU should have APLS trained staff. Managers told us this risk was mitigated as the PAU formed part of Skylark ward footprint who supported in the event of an emergency. The on-call resuscitation team held an APLS or EPALS trained staff member in line with the trust resuscitation policy.

Furthermore, data provided to us following our inspection showed 17 out of 19 (89%) RNs working in the neonatal unit had completed neonatal life support training. A plan was in place for those who had not completed it to become competent in neonatal life support.

The service could not provide assurance that clinical staff were provided with training on recognising and responding to children and young people with mental health needs, a learning disability or autism. Following our inspection, the

service told us they did provide staff with 'workshops and bite sized learning sessions on specific mental health issues'. However, they did not record or monitor staff attendance. The service told us they intended to implement a mandatory learning disability training module in the near future. Most RNs and non-registered nursing staff (98%) on Skylark ward and all staff on the neonatal unit had completed conflict resolution training. Some staff on Skylark ward completed a paediatric/adolescent specific de-escalation training. Data provided to us following our inspection demonstrated 52% of RNs on Skylark ward had completed de-escalation enhanced skills training. This was not mandatory at the time of our inspection.

Managers told us practice development nurses and human resources monitored mandatory training and alerted staff when they needed to update their training. The practice development nurse kept a log of staff training requirements which they used to remind staff when they were due to complete training.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it. Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Systems and processes to check nationally approved child protection information sharing systems and assessing a patients' social background were in place but not fully embedded.

Registered nursing (RN) staff received training specific for their role on how to recognise and report abuse. The 85% compliance target was met for safeguarding adults (89%) and children (97%) level 3 on Skylark ward, which included the PAU and the neonatal unit.

Non-registered nursing staff completed level 2 safeguarding adults and level 3 safeguarding children. The 85% compliance target was met on Skylark ward, including the PAU for safeguarding adults' level 2 (92%) and 100% of staff had completed level 3 safeguarding children. However, the 85% target had not been met for safeguarding adults and children (80%) on the neonatal unit.

Medical staff received training specific for their role on how to recognise and report abuse, however, compliance was variable. For example, data provided to us following our inspection showed the 85% compliance target was met for safeguarding children level 3 training (88%) but not for safeguarding adult level 3 (65%). However, medical staff said they understood how to identify and act on an adult safeguarding concern.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff provided example of how they identified children at risk. During our inspection we saw examples where staff had worked with other agencies to safeguard a child and ensure a safe discharge.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff provided us with examples of where they had previously made safeguarding referrals for both children and adults. Details of local safeguarding arrangements were displayed in the department for staff to reference. Data provided to us following our inspection showed from December 2021 to November 2022, Skylark ward had made 12 referrals to the Multi-Agency Safeguarding Hub and the neonatal unit made 4. The trust wide safeguarding steering group had oversight of safeguarding risks on the ward and referrals made.

Systems and processes to assess a child's social history and check nationally approved child protection information sharing systems were in place but not effectively implemented. Each child admitted to Skylark ward and the PAU underwent a nursing assessment which included a safeguarding and social history assessment. We reviewed 13 patient

records and found 7 did not demonstrate an electronic system check had been completed to determine whether there had been any previously documented safeguarding concerns. Nine records did not document that a full social background assessment had been completed. For example, the child's social care status, national child protection systems check undertaken and whether they were previously known to the service.

Systems were in place to add an alert to electronic patient records should there be a safeguarding concern or specific actions to take. For example, to identify frequent attenders or record individualised safeguarding risks. However, in 2 records we reviewed where a patient was identified as a regular attender, there was no evidence of any actions taken in response to this as indicated on the nursing assessment document.

Documentation of actions taken to safeguard patients was not always recorded in nursing or medical records. We saw examples of safeguarding concerns being documented in ongoing nursing records. However, we did not see evidence of actions being taken in response to the concerns documented. For example, we saw concerns of a safeguarding nature being noted on 4 occasions in a patient record, however, we did not see any evidence that action had been taken to safeguard the child. We discussed this case with the safeguarding children's lead nurse who advised us incidents had been reported and they were keeping a log centrally of actions taken. The safeguarding children's lead nurse provided assurance that all incidents had been reported externally to the safeguarding children team and were working with the ward team to plan a safe discharge. However, this was not documented in the nursing records. We were concerned there was a risk safeguarding information could be missed and there was a risk of key information not being shared with other professionals involved in plans to safeguard the patient from harm or neglect.

The service had several systems for recording safeguarding information which did not support staff to effectively assess and document the risks. For example, safeguarding risks were recorded on an electronic system, in the paediatric emergency department assessment, in the ward nursing records and centrally with the trust wide safeguarding team. There was a potential risk of missing a child that needed to be safeguarded because the records did not correlate. The hybrid system of record keeping posed a safety risk as documentation was inconsistent across them both.

Following our inspection, the trust provided us with their children and young person services improvement plan. By the end of January 2023, the trust intended to introduce a set of minimum standards for documenting interactions with safeguarding leads and trust wide team in patient records. A safeguarding documentation standards audit had been implemented following our inspection to improve practice. This was planned to be reported to the trust wide safeguarding steering group.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Ward areas were not always clean and well-maintained. We found patient cubicles and toilets were not always clean on Skylark ward. For example, we found a significant amount of brown dirt on the inside of the bathroom door in cubicles 5 and 13. Both bathrooms had dirt in the corners of the shower area and behind the toilet. We found dust on cot rails in 5 cubicles we visited. The ward undertook monthly 100 step audits which checked compliance against hygiene and cleanliness standards. We reviewed audits completed from June to November 2022 and found an average 93% compliance across the 4 audits completed over this time period. Dust found on equipment and in-patient bays and cubicles was a repeated theme, however, there was no evidence of actions being taken to improve this.

Equipment was not always clean. For example, we found a dirty potty in bay 1 toilet and dirt on weighing scales in the treatment room on Skylark ward. We were not assured all equipment had been cleaned as there were no stickers on equipment to say when it had last been cleaned. This was cited as a repeated concern in 100 step audits we reviewed from June to November 2022, yet we found no evidence of action taken to address this.

We received variable feedback from parents we spoke to in relation to hygiene and cleanliness. Some parents felt the ward was generally clean and tidy, however, others felt it was not always clean. For example, a parent told us the high dependency unit had been unclean and untidy whilst they had been present with their child. Another parent told us they raised a complaint about hygiene and cleanliness having found significant dust in their child's room.

Staff did not always follow infection control principles. Patients with infections or at risk of harm from infections were clearly identified and cared for in side-rooms. However, we observed on regular occasions throughout the day of our inspection on 19 December 2022, cubicle doors were left open for long periods where patients were being barrier nursed due to having a communicable disease. This meant there was a risk of cross infection.

Staff we spoke to during our inspection understood the process for screening patients for infectious diseases and where there was a risk, the process for isolating patients. The ward had 16 cubicles which meant there were enough rooms to isolate patients if required.

Vascular access information was not routinely documented in the nursing assessment document or on a sticker applied to the cannula site. Ongoing Visual Infusion Phlebitis (VIP) scores were not routinely assessed each shift and documented on the care plan in the nursing document in line with trust policy. We reviewed 2 patients with a cannula in place and found there was no evidence of when the cannula was inserted or that the VIP care plan had been implemented. One patient told us they experienced a burning sensation but there was no evidence of this being documented. This meant there was a risk of infection developing and it not being identified in a timely manner.

Staff used PPE. For example, whilst some cubicle doors were left open, we saw staff put on appropriate PPE before entering a room being barrier nursed. During our inspection it was difficult to observe compliance with good hand hygiene as it was often undertaken in patient cubicles. However, most parents and patients we spoke to told us staff washed their hands regularly and used hand sanitising gel. Face masks and alcohol hand gel were freely available in all areas we visited. Handwashing facilities were appropriate and accessible. All staff adhered to being bare below the elbow.

Following our inspection, the service provided assurance of action being taken to improve IPC practice and cleanliness of the environment. Staff were asked to read the standard operating procedure for isolating patients with suspected or confirmed infection to ensure the processes required to prevent cross infection were undertaken. Daily ward monitoring of cleaning standards had been implemented by the domestic supervisor. Cleaning audits increased to once weekly. Audits of VIP score assessments and daily cannula care audits had been implemented. The trust IPC lead commenced twice weekly 100 Step checks and weekly matron/IPC walk abouts to highlight issues and support staff training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Clinical waste was disposed of safely.

The environment and layout of Skylark ward did not always support the safe management of patients presenting with acute mental health concerns or challenging behaviours. For example, most cubicles were in close proximity which meant easy access into other patient's rooms and access to equipment left out when not in use. We observed cubicle

doors only opened 1 way and en-suite toilets had locks on which meant there was a risk a patient could potentially lock themselves in. Managers told us they were unable to remove all ligatures from cubicles, such as oxygen tubing and emergency cords as these would be required in an emergency. During our inspection we were aware of an incident where a patient had locked themselves in a bathroom and used emergency equipment as a ligature. Managers and staff recognised the environment was not suitable, however, there were limited facilities locally to support patients whilst awaiting a mental health assessment.

Managers told us they mitigated environmental risks by placing the patient in an observable cubicle with safety curtain rails and window blind rails with magnetic fixings. Patients were provided with 1 to 1 minimum care from staff. We saw this was in place for patients at the time of our inspection. An enhanced observation assessment was in place which required staff to outline environmental dangers to be removed. However, we did not see evidence these were always completed in 4 records we reviewed where a patient was on a self-harm pathway.

Processes to assess environmental risks were not regularly completed. Following our inspection, we requested environmental risk assessments including annual ligature risk assessments. A ligature risk assessment had not been completed in the 12 months prior to our inspection. We were advised risk assessments were not completed as the risks were incorporated on the service risk register. Having reviewed the risk register we were not assured the risks had been robustly assessed to mitigate the risk of harm to self and others. Following our inspection, the service undertook a ligature risk assessment. The risk assessment identified ligature points and outlined whether any further action was required to mitigate the risks. A self-harm audit to include compliance with risk assessment completion had been implemented monthly following our inspection.

The design of the environment did not always follow national guidance. The neonatal unit was identified as an area of concern and added to the service risk register in relation to the layout of the unit. Patients were not always visible to nursing staff which meant should a patient suddenly deteriorate; they may not be able to quickly identify the patient deteriorating. Not every cot space had access to air supply which limited the number of patients who could be cohorted in each room. Furthermore, there was only 1 call bell in each of the bays. However, mitigations were in place to reduce these risks. Patients were cohorted together in as few rooms as possible. A minimum of 1 or more nurses were assigned to each room, depending on the level of care being provided. Where a nurse left a room, this was handed over to another staff member. Managers told us they did not accept new admissions if a patient could not be cared for safely. Managers told us a business case had been submitted to refurbish the area to improve visibility and access to equipment.

Arrangements were in place to ensure children and young people wards were secure. During our previous inspection in 2017, we were concerned access to clinical areas was not as secure as it could be and store cupboards on Skylark ward were accessible to unauthorised persons. During this inspection we saw improvements had been made. The main entrance to Skylark ward and the neonatal unit could only be opened by a dedicated key card. Staff also had to electronically open doors for anyone without a swipe card to leave the ward. We saw staff use an intercom to check the identity of people requesting access to wards. All doors to non-patient areas and store cupboards were electronic key card access only to prevent unauthorised access to items which could be harmful or confidential. The PAU had a waiting area which was in the line of sight of the ward and PAU reception.

The maintenance of facilities and equipment did not always keep people safe. However, the service took immediate action to address areas of concern shared with them at the time of our inspection. During our inspection on 6 December 2022, we observed medical air sockets had not all been capped off when not in use. For example, we observed medical air had not been capped off in cubicle 2, 3 and in the high dependency bay. This meant measures to prevent unintentional use of air rather than oxygen were not effectively implemented and patients were exposed to on-going risk of harm. The trust took immediate action and during our follow up inspection on 19 December 2022, we found all air

ports where not in use had been covered. All rooms with medical air had safety posters up advising of the need to remove flow meters and recap the valve after use, to avoid accidental connection to air. A trust wide alert and learning briefing had been sent out to staff in a patient safety newsletter, and senior nurse audits had been undertaken which demonstrated where the air was not being used for treatments, all the valves had been covered, showing 100% compliance.

Ward based point of care blood gas machines on Skylark ward were not electronically linked to the patient record. This meant there was a risk the results could be accidentally placed in the wrong patient record and impact clinical decision making for the wrong patient. The blood gas machine on Skylark ward provided staff with receipts with the results on. We saw the receipts were copied into paper medical records. However, the unique identifier recorded did not always reflect the patient hospital or NHS number. For example, we saw '11111' in a record we reviewed which did not correspond with the individual patient. We were not assured there was an effective system in place to check the results were recorded in the correct patient record. Following our inspection, the trust provided assurance immediate action had been taken. The machines had been connected to the Trust system and access was limited to staff who had undergone appropriate training. This meant that 100% of tests undertaken following our inspection were linked to the individual patient record. Most registered nurses (91%) and medical staff (85%) had completed training with a plan for remaining staff to complete this before the end of January 2023. During our follow up inspection on 19 December 2022, we reviewed blood gas machine receipts in patient records and found all receipts recorded in patient files had their hospital number which provided assurance immediate improvement had been made.

Staff carried out daily safety checks of emergency equipment, however, they were not always effective. Staff had access to specialist paediatric and neonatal emergency equipment in all areas we checked. We saw daily and weekly safety checks were generally up to date. Equipment on all 4 emergency trolleys we checked were in good condition and in date. However, we found out of date adrenaline on an emergency trolley on Skylark ward. We found a sealed bag with an expiry date of October 2022. In the bag contained 8 Adrenaline injections 1:10,000. Weekly checks of the trolley had been undertaken and staff had documented checking the content on the day of our inspection. This meant there was a risk a patient could be administered out of date medicines. Furthermore, systems and processes in place to check the safe storage and use of medicines were ineffective. During our follow up inspection on 19 December 2022, we checked 2 emergency trolleys and found all equipment and medicines were in date. However, 1 emergency trolley containing medicines was unlocked and unattended. We were concerned this could have been accessed by unauthorised persons. We escalated this to the ward matron, and it was locked.

Following our inspection, the trust told us a review of the robustness of trolley checks was in the process of being completed and the trust policy had been circulated to staff. An audit completed by the service following our inspection demonstrated 100% compliance with resuscitation trolley checks.

Children, young people and their families could reach call bells and staff generally responded quickly when called. Most parents we spoke to told us in general staff responded to call bells within reasonable timescales. Most parents told us they knew staff were very busy so if there was a delay they would go and find a staff member and they were generally responsive. Patients who were unable or unlikely to use call bells, such as very young patients were kept under close observation of the nursing staff and had regular contact with other non-registered nursing staff.

The service generally had suitable facilities to meet the needs of children and young people's families. There was a family room with play equipment and a sensory room. Use of these facilities was supported by staff including play therapists. Beds were available for 1 parent to stay overnight. Several patients commented they did not have access to kitchen facilities to make a drink or heat their child's milk up. Parents told us they had to ask staff to do this for them and felt if they had access it would take the pressure of staff.

Services for children and young people

The service did not always have enough suitable equipment to help them safely care for children and young people. Electronic handheld devices were available to record patient observations. These were stored in each cubicle and bay. Each cubicle also had equipment required to manage a deteriorating patient and monitors for ongoing monitoring of vital signs. Staff told us they generally had enough equipment; however, thermometers were not always readily available. Staff told us the service purchased these, but they often went missing. In 7 records we reviewed we found gaps in measuring a patient's temperature when undertaking patient observations of vital signs.

Each cubicle had a plastic box for parents to place wet nappies in so they could be weighed by nursing staff. We saw these were being used during our inspection and most parents told us they were regularly weighed by staff. Furthermore, there were weight scales in each cubicle so that nappies could be weighed and recorded on fluid balance charts to measure urine output. Nappies were appropriately disposed of once they had been weighed.

Staff carried out daily safety checks of specialist equipment. Maintenance staff completed regular safety checks of electrical equipment. Out of 10 pieces of equipment we looked at, all had a sticker to show when it was last tested and were in date.

Prior to our inspection we were aware of an incident where a child fell out of a cot due to the cot not being locked correctly. During our inspection we found cot checks were undertaken and cots had been locked correctly before leaving a child. Staff were aware of safety risks of not checking cots. They could describe how to use and lock a cot and provided assurance this was explained to staff during their induction. Some parents we spoke to told us staff had explained the importance of securing cots if they left their child unattended.

Staff disposed of clinical waste safely. Waste segregation was in place and PPE, such as aprons and gloves were disposed of in clinical waste bins.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each child and young person. Risks were not always removed or minimised. Staff did not always effectively identify and quickly act upon children and young people at risk of deterioration. Processes were in place to safely manage patients requiring a higher level of care.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration. Staff used the Paediatric Early Warning Score (PEWS) system to assist them with the early recognition of sick patients and management of any deterioration. Vital signs, such as heart rate, respiratory rate, blood pressure, oxygen saturation, temperature, and behaviour were used to assess each child's clinical status. This was immediately recorded on an electronic system which generated a score alerting staff to any potential deterioration. A new-born early observation warning system was used on the neonatal unit which was specific to neonates. At the time of our inspection 75% of registered and non-registered nursing staff had completed PEWS training on Skylark ward and 94% of registered nurses on the neonatal unit.

PEWS were completed but not always on time. Fourteen records we checked demonstrated regular PEWS monitoring. However, in 12 records these were not always completed within appropriate timescales. For example, a patient who required their observations being repeated after 1 hour did not have them repeated for 3 hours and 30 minutes. A patient who required observations being completed after 30 minutes were not repeated for 1 hour 30 minutes. We saw in another patients records who had deteriorated, once stabilised did not have any further observations completed for over 6 hours when required after 4 hours. Furthermore, we identified neurological observations had not been completed 2 hourly in line with trust policy for a patient who had fallen and sustained a head injury. This meant staff systems to monitor and quickly identify the deteriorating patient were not always effective.

Temperatures were not consistently recorded when undertaking patient observations. In 7 records we reviewed we found gaps in measuring a patient's temperature when undertaking patient observations of vital signs. The frequency of missed temperatures varied from 1 occasion to 30 occasions. For example, we found in one record there were 30 temperatures not recorded from 15 to 19 December 2022 and in another there were nine not recorded from 17 to 19 December 2022. The reason given on the electronic monitoring system was 'unmeasurable other reason'. This meant the PEWS score was not always an accurate reflection of the level of deterioration where temperatures were not recorded. This increased the risk of a deteriorating patient not being identified and escalated in a timely manner.

PEWS were generally escalated in a timely manner; however, the patient was not always reviewed in a timely manner. During our inspection, we found, nursing staff escalated concerns to medical staff in a timely manner. In general, patients were seen quickly by medical staff. For example, during our inspection on 19 December 2022, we observed a nurse escalating a deteriorating patient to a doctor who reviewed the patient immediately. However, there were sometimes delays in medical reviews being undertaken outside of normal working hours. For example, a patient with signs of deterioration was escalated to the on call medical team at 10.30pm on 17 December 2022 but was not reviewed until 1.30am on 18 December 2022. Another patient showed signs of deterioration at 8.16pm on 4 December but was not reviewed until 10.30pm.

The service undertook deteriorating patient audits monthly. Audits assessed compliance against observations, timeliness of escalation and use of a Situation, Background Assessment Recommendation (SBAR) communication tool in escalating a patient. Ten audits undertaken from November 2021 to October 2022, showed an average 95% compliance with audit standards. Based on what we found during our inspection, we were not assured the audits were robust in identifying compliance with PEWS standards. Furthermore, we did not see evidence of an SBAR communication tool being used in any record we reviewed where a patient was escalated.

Staff told us an increase in patients with higher support needs and staffing levels impacted their ability to complete observations on time. Following our inspection, the service took immediate action to improve compliance by implementing weekly audits and sharing learning. An audit undertaken following our inspection showed 83% compliance with PEWS completions with a planned trajectory to achieve 90% compliance over a 6-month period. The service was on track to achieve this.

Most patients underwent a needs assessment on admission to Skylark ward which was included in the nursing assessment document. It included a review of normal and recent changes in relation to airway and breathing, circulation, bowel habits, urine input and output, disability, pain, sleep, mobility, observations and communication. We saw this was completed in 13 out of 14 records we reviewed.

Staff did not always complete risk assessments for each child and young person on admission using a recognised tool. Furthermore, reviews of risk assessments were not consistently undertaken. During our previous inspection in 2017, we found the service did not have a risk assessment tool in use for the risk of development of pressure ulcers or a tool in use for the risk of skin damage caused by continuous positive airway pressure devices (CPAP). We also found assessments of patient's nutritional needs had not been completed in 7 out of 10 records we reviewed. During this inspection we found limited evidence improvements had been made or fully embedded. For example, we found:

- The service had implemented a recognised risk tool to assess the risk of pressure ulcers. However, they were not consistently completed. During our inspection on 6 December 2022, we found only 1 in 4 risk assessments had been completed. On our follow up inspection on 19 December 2022, we reviewed a further 10 records and found some improvements had been made. We found an initial risk assessment had been completed in 5 out of 10 records. However, ongoing reviews in line with the trust policy were not always completed.

- Patients who were assessed as high risk of developing a pressure sore based on the risk assessment, did not have any personalised plans in place to mitigate the risk. We reviewed the records of a patient who was assessed as very high risk. We found no evidence actions had been taken to mitigate the risk in line with the risk assessment. For example, hourly checks, appropriate mattress and skin maps completed. The care plan was not personalised, and no actions were documented to mitigate the risk. Furthermore, we found risk assessment documentation did not always support staff to effectively assess and mitigate risks.
- There was variable compliance with completion of fluid balance monitoring. Risk of dehydration assessments and fluid formula guides were not completed in any of the records we reviewed. This meant it was not always clear whether a patient was at risk of dehydration or whether they required fluid input and output monitoring. Three out of 14 patients did not require fluid monitoring. However, of the 11 patients who did, only 3 were fully and consistently completed. Two did not have any ongoing monitoring and 6 were inconsistently completed. For example, the total inputs and outputs were not always documented as required and there were periods of time or days not completed. This meant there was a risk that clinical decisions made were based on inaccurate information.
- Where patients were on CPAP, we did not see evidence of a risk assessment tool in use for the risk of skin damage. We reviewed a patient record who had previously sustained markings on the skin from CPAP, however, there was no risk assessment or body map completed. Furthermore, there was no evidence of any actions taken to mitigate the risk.
- We did not see evidence a nutritional risk assessment was in place to assess the risk of malnutrition. We did not see evidence a patient's nutritional needs were effectively assessed with a clear plan in place for how the child will be feeding or supported to feed. However, we were assured where a patient required specialist nutrition, such as nasogastric feeds and percutaneous endoscopic gastrostomy feeds, the standard care plan was personalised to ensure the patients' needs were met. It was not clear which patients required nutritional intake monitoring and compliance with food charts was inconsistent. For example, we found food charts were available to staff and were used, however, they were not always fully completed and there were some missed days in some records.

Staff knew about but did not always effectively deal with specific risk issues.Staff were provided with training in the identification and treatment of sepsis. All staff we spoke to could describe the process for assessing and escalating concerns in relation to sepsis. Nursing staff told us when they escalated concerns, the medical team generally reviewed the patient in a timely manner. However, we were not assured where clinical judgement was required to assess the risk of sepsis, staff considered this as part of the screening process. For example, the service sepsis screen stated patients at risk of serious infection as a result of indwelling lines, chronic disease and pneumonia should be considered for possible sepsis. In 6 records we reviewed where the patient was assessed as low risk as their PEWS was less than 5, all had factors present which made them more at risk of developing an infection. There was no evidence this was considered in the screening process and in line with the trust policy and screening tool. For example, in 1 case, a working diagnosis was pneumonia and another a site infection. Both PEWS was less than 5 at the point the screen was completed. However, staff did not recognise these risk factors as increasing the risk of sepsis and in both cases remained low risk.

Sepsis screening was not always completed in line with trust policy and there were some delays in completing them on admission to the ward. In 1 record there was no sepsis screen completed in the paediatric emergency department or on admission to Skylark ward. This was not in line with the trust policy; however, the patient was not being treated for a physical health condition. There were sometimes delays in the sepsis 6 screen being completed. For example, we found in 1 record a patient had not been screened until 17 hours after admission and a further 2 after 2 hours and another 2 hours 30 minutes after admission to the ward. Furthermore, an incident we reviewed following our inspection showed there was over a 7-hour delay in a sepsis screen being completed for a patient who had later been diagnosed with sepsis.

Services for children and young people

Sepsis 6 bundles and action tools were not always completed. We found 3 records where the sepsis 6 bundle had not been completed and a rational had not been provided for it not being completed, where a patient was assessed as high risk of sepsis. This meant patients who were high risk of sepsis were being exposed to potential harm as actions to treat sepsis were not documented as undertaken. The service could not be assured patients were assessed and treated within the hour in line with nationally recognised treatment pathways for sepsis.

In 1 record where the patient was assessed as low risk of sepsis yet being treated for an infection, it was documented there were delays in 'urgent' bloods being taken and the administration of intravenous antibiotics being administered. The patient was neutropenic and being treated for a site infection. We were not assured the patient had been appropriately assessed or that actions to treat an infection in a high-risk patient were undertaken in a timely manner.

This meant patients were being exposed to harm as there were missed opportunities to identify and treat patients who were high risk of sepsis in line with trust policy and national guidance. We escalated our concerns to the trust following our inspection. Harm reviews were undertaken of each case. The harm reviews found no evidence of moderate or above harm having occurred, but recognised staff did not follow trust policies and procedures. The themes we identified were consistent with feedback we received which triggered our inspection. We were also aware of incidents where a patient was assessed as low risk yet developed sepsis whilst in hospital.

Compliance with sepsis screening and treatment was not routinely audited. Following our inspection, we requested sepsis audits, however, the service was unable to provide us with this information as they had not undertaken any sepsis audits from April to October 2022. Managers told us they had not been completed as there was not a specialist paediatric sepsis nurse to undertake them. This meant there were missed opportunities to identify non-compliance and share learning with staff to improve practice and safeguard patients from ongoing risk of harm.

Following our inspection, the trust provided us with an action plan to make immediate improvements to the screening and treatment of patients at risk of sepsis. Actions included increasing staff knowledge through training and ward-based skills sessions. The trust sepsis team and pathway to excellence lead nurse were tasked to support improvements across CYP services in sepsis identification and management. Sepsis audit frequency had increased to once weekly. The trust undertook a sepsis audit following our inspection which demonstrated 79.8% compliance with sepsis pathways. An action plan was implemented to improve compliance with a target of 90% to be achieved over a 6-month period.

Standard operating procedures were not in place to ensure there was a clear pathway for patients attending the PAU. For example, we did not see evidence there were processes in place on the PAU to indicate which patients were suitable to be assessed and seen in the PAU, the patient journey, roles and responsibilities of nursing and medical staff and escalation processes. During our inspection we were unable to see the PAU operating as the service had been temporarily closed due to unprecedented demand for beds. However, prior to our inspection we were aware of an incident where a patient had been discharged from the PAU without a senior medical review.

Processes were in place to safely manage patients requiring a higher level of care. A policy was in place to support staff in the management and transfer of the critically ill child. The service was not commissioned to provide high dependency care; however, they had experienced a significant increase in the number of patients presenting with higher dependency needs, such as severe respiratory illnesses who required vapotherm or Continuous Positive Airway Pressure (CPAP) devices for small babies. Skylark ward had 2 beds in a shared room which they used to care for patients who had 'higher dependency needs'. The beds were also used for patients awaiting transfer to a Children's Intensive Care Unit (CICU). The service had 2.5 whole time equivalent registered nurses with a high dependency care qualification. Furthermore, 79% of staff had completed training to enable them to care for patients on CPAP. Staff were allocated to look after high dependency patients according to their skills and experience.

Services for children and young people

Children who required intensive care were transferred to a tertiary centre. Paediatric patients were collected by another NHS acute hospital retrieval team and neonates transferred by the neonatal network retrieval team. Where a patient could not be immediately transferred, processes were in place to treat and stabilise the patient on site. The paediatric team was supported by the trust intensive care and anaesthetics team to provide intubation, ventilation, central lines and monitoring, if required. The adult intensive care onsite was also used on occasions to treat and stabilise a patient requiring intensive care. The intensive care had 2 monitors which could be adjusted for paediatric care. The paediatric intensive care retrieval units also supported staff in the safe management of patients with higher dependency needs providing consultation and onsite management in caring for the patient whilst awaiting an CICU bed. We saw evidence in patient records of local retrieval units being contacted for advice and consultation and onsite care and treatment being provided.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). Staff had access to rapid assessment with Child and Adolescent Mental Health Services (CAMHS) when needed, either in person or by telephone. Skylark ward had an established joint working initiative with CAMHS. We saw examples of positive and regular communication with CAMHS to support the safe management of patients. In 2 cases we reviewed we saw patients underwent an assessment with CAMHS. We found evidence of regular contact with CAHMS for support in managing patients whilst they were awaiting an assessment.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. The trust had a policy for the 'observation of paediatric patients with mental health problems, self-harm and/or acute behavioural disturbances'. The policy was written in conjunction with a CAMHS local to the hospital. We reviewed the records of 4 patients admitted with acute mental health concerns and self-harm. All patients underwent a self-harm risk assessment and in 3 cases we saw staff noted on the end of the risk assessment to say they had reviewed it. There was a formal enhanced observation risk assessment to determine whether 1 to 1 care was required, if the environment was suitable, and whether adjustments were needed. However, we did not see evidence of an enhanced observation assessment being completed in any record we reviewed in line with policy.

Patients at risk of self-harm or suicide were provided with continuous supervision and usually located in cubicles within close proximity and line of sight to the nurses' station to provide extra monitoring.

Ward rounds included all necessary key information to keep children and young people safe. Ward rounds were undertaken daily where all new patients and existing patients were reviewed. They were multi-disciplinary, and we observed a good level of input from both nursing and medical staff. All records were reviewed including electronic records and paper records in making decisions about a patient's care and treatment during ward rounds.

Nurse staffing

The service did not have enough nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. The service establishment at the time of the inspection meant the service could not meet safe staffing levels across the service. Temporary staff did not always receive a full induction. Processes were in place for managers to review staffing levels and mitigate risks, however, these mitigations were not sustainable overtime.

The service did not have enough RNs and support staff to keep children and young people safe at the time of our inspection. Staffing levels across children and young people services was on the service risk register and reported as a risk on the integrated governance report. For example, in November 2022, the report stated staffing had been red on the majority of Skylark ward shifts over the month prior due to staff unavailability and acuity of the ward.

Services for children and young people

All staff we spoke to on Skylark ward during our inspection told us they were short staffed, and most told us staffing levels were unsafe. They did not consider staffing levels allowed them to safely care for increasing numbers of patients with complex health needs requiring high dependency care. For example, patients on CPAP or vapotherm. They told us it also impacted their ability to complete patient observations, risk assessments and administer medicines on time. Records we reviewed during our inspection showed patient observations were often not completed on time. Furthermore, we saw some medicines had not been administered on time. For example, in 1 record we saw a 2 hour 15-minute delay in the administration of 'urgent' intravenous antibiotics.

Most parents we spoke to on Skylark ward commented staff were very busy. Parents of 3 patients asked to speak to us during our inspection to share concerns regarding safety in relation to staffing levels. They told us staff were trying their best but did not have the time to provide their child with the level of care needed whilst in hospital, particularly where a child had complex needs. For example, providing regular suction, regular observations and administering medicines and feeds on time.

Managers told us at the time of our inspection, staffing levels meant they could not meet the recommended level of nurses in accordance with the RCN safer staffing guidance. RCN guidance states that there should be a ratio of 1 nurse to 3 patients for children under the age of 2 years, a ratio of 1 to 4 for patients over the age of 2 years, during the day and night shifts. During our previous inspection in 2017 we found the service could not provide 1 nurse to 2 patients staffing ratio in the High Dependency Unit (HDU), when required, in line with the Royal College of Paediatrics and Child Health 'High Dependency Care for Children, Time to Move On' (October 2014). During this inspection, managers told us this continued to be a risk. Whilst the service was not commissioned to provide high dependency care, managers told us they were increasingly admitting patients who met the level 2 critical care criteria for high dependency care. The November 2022 integrated governance report stated Skylark ward acuity had remained high in the month of November with 4 to 8 HDU children at any one time. The neonatal unit supported the ward by moving staff to cover. However, we were not assured adequate action had been taken to address the ward establishment to support management of patients requiring high dependency care since our previous inspection in 2017. This meant the ward continued to be unable to provide the level of care required for patients with higher dependency needs.

The neonatal unit did not meet the British Association of Perinatal Medicine (BAPM) recommended staffing levels of 'Qualified in Specialty' (QIS) trained nurses. It recommended 70% of RNs should be QIS trained. During our previous inspection in 2017 we found 66% of neonatal nurses had completed their post registration qualification, which did not meet the 70% standard. We were told there were more additional staff completing the qualification. However, during this inspection, we found the number of QIS trained staff had deteriorated. At the time of the inspection, 52% of staff were QIS trained which had increased from 38% in September 2022. Managers told us the service was on track to be at 70% over a 2-year period. Whilst the service was not meeting the recommended levels, we saw there were 2 staff undergoing training and 2 staff per year expected to complete the training. At least 2 QIS trained staff were added to the rota on the neonatal unit. From 1 September to 30 November 2022, there were no shifts reported by the service to flag staffing levels were unsafe over that period. There were 2 'staffing' incidents recorded for the time period which related to limited QIS staffing. Incident reports showed appropriate actions were taken by the service to reduce potential risks with unit staff volunteering to work with short notice and suspending new admissions.

The service had high vacancy rates across children and young people services. There was an 18% vacancy rate for registered nurses on both Skylark ward and the neonatal unit. On Skylark ward, there were 7.5 whole time equivalent band 5 nurse vacancies and 6 registered nurse vacancies on the neonatal unit. The vacancy rate for non-registered nursing staff was 12% on the neonatal unit and there were no vacancies on Skylark ward.

The service had variable turnover rates. Data provided to us following our inspection showed from June to October 2022 the average turnover rate for registered nurses on Skylark ward was 5.3%. Turnover rates had reduced over this time period and were at 4% in October 2022. The average registered nurse turnover rate on the neonatal unit was 14.5% over the same time period increasing to 17% in October 2022.

Turnover for non-registered nursing staff on Skylark ward averaged 7.8% from June to October 2022 with an increase from 7.4% in September to 9.6% in October 2022. Non-registered nursing staff turnover on the neonatal unit remained consistently low with an average 2.3% over this time period.

The service had variable sickness rates. Data provided to us following our inspection showed the average sickness rate for registered nursing staff on Skylark ward from June to November 2022 was 5.8% and 6.6% on the neonatal unit. The sickness rate for non-registered nursing staff over the same period was 11.4% on Skylark ward and 5.1% on the neonatal unit.

The number of nurses and healthcare assistants did not always match the planned numbers. On the day of our inspection, Skylark ward had 6 registered nurses on shift but required 7. Data provided to us following our inspection showed from June to November 2022, the average shift fill rate on Skylark ward in the day for registered nurses was 71% and 75% at night. Over the same time period on the neonatal unit, the fill rate was 79% in the day and 78% at night.

The average non-registered nursing staff fill rate on Skylark ward from June to November 2022 was 90% in the day and 107% at night (ranging from 30% in June to 157% in November 2022). On the neonatal unit, we did not receive complete data. However, from June to August 2022, the average fill rate was 114% for non-registered nursing staff.

Staff told us where shifts were unfilled, they were often filled with adult trained registered nurses from other areas who were not skilled or experienced in caring for paediatrics. This meant they could not meet all patient care needs. Some parents we spoke to told us their child was sometimes assigned adult trained nurses and did not consider they had the skills to safely care for their child.

Processes were in place to review staffing levels daily. Registered nurse and non-registered nurse staffing levels were planned and reviewed against the actual numbers. A safe staffing tool was used to analyse the staffing levels based on the acuity of patients on the ward. This indicated where more staff were required to ensure safe staffing. Matrons for Skylark ward and the neonatal unit met daily to discuss staffing levels across the service. Where areas were short staffed, staff were moved. For example, if the neonatal unit cot occupancy was low and Skylark ward staffing was below safe levels, staff would be moved to support Skylark ward. Managers told us on occasions practice development nurses and ward sisters were counted in the numbers to support the ward. Matrons attended twice daily trust wide staffing meetings to present staffing levels and acuity concerns and seek support from the trust to mitigate staffing risks.

Staffing establishment reviews recently undertaken at the time of our inspection showed the number and grade of staff had not been accurately calculated, in accordance with national guidance. For example, Skylark ward and the PAU had undergone a nurse establishment review 3 weeks prior to our inspection. The review identified an increase to 8 RNs per shift was required to maintain safe staffing levels on the ward, safe staffing of the HDU when in use and to ensure there was always a supernumerary nurse in charge. A business case was in the process of being produced at the time of our inspection.

A business case had been submitted for the neonatal unit to increase the number of nurse associate positions and registered nurses. This also included a business plan to enable staff to attend QIS training. The service was budgeted for

18.8 whole time equivalent (WTE) QIS trained registered nurses. At the time of our inspection there were 13.9 in post. To meet the 70% occupancy level this would need to increase to 20.9 WTE. Recruitment was underway at the time of our inspection. The establishment review also resulted in a ward manager and practice development nurse position being created to support safe staffing levels.

The service had increasing rates of bank and agency nurses. Data provided to us following our inspection showed from June to November 2022, the service requirement to use bank and agency staff to cover shifts had increased overtime. Managers were unable to limit their use of bank and agency but did request staff familiar with the service. However, this was not always possible and there had been occasions where staff without paediatrics skills and experience had been allocated to work on the ward.

Managers did not make sure all bank and agency staff had a full induction and understood the service. During our inspection we did not see evidence that all bank and agency staff had undergone an induction to the ward. Following the inspection, the service provided assurance 100% of all temporary staff working on Skylark ward had since undergone a local induction before commencing their first shift. A project to review and establish a paediatric competency package for adult nurses working in paediatric services was commenced due to be implemented by 6 January 2023.

Following our inspection on 19 December 2022, the trust provided us with a detailed action plan which demonstrated how they intended to mitigate staffing risks. The trust provided assurance that the staffing levels would increase with immediate effect so there was a minimum of 1 nurse to 4 patients plus a supernumerary nurse in charge. This meant there would be 8 registered nurses and 2 HCAs on duty which would enable the service to meet safe staffing levels and high dependency safe staffing levels when required. The service reduced its bed capacity, temporarily closed the paediatric assessment unit and increased its bank staff usage to enable the increased staffing levels to be immediately implemented. The service also provided assurance of medium to long term actions to sustain the increase in staffing moving forward. This included setting a target for a minimum 80% roster fill rate and an agreement for 2 additional temporary staff cover day and night. The service intended to undertake a recruitment campaign to fill vacancies.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

All grades of doctor were available 24 hours a day, 7 days a week. Twelve consultants worked across children and young people services. This included providing cover to the neonatal service, paediatric emergency department, the paediatric assessment unit and Skylark inpatient ward. Consultant cover was not in line with the Royal College of Paediatrics and Child Health standards. Consultants provided daily onsite cover until 7pm each day. This meant the minimum 12-hour consultant cover standard was not met. Ward rounds were undertaken daily and at times of high acuity twice daily. A consultant was available to review patients in the paediatric assessment unit or provide on call support overnight and at weekends. The service always had a consultant on call during evenings and overnight. On call consultants were available within 30 minutes out of hours and were available to advise on clinical management or to attend the hospital. In 10 records we reviewed we saw evidence of minimum daily consultant reviews of all patients.

The service did not always have enough medical staff and the vacancy rate was high. Data provided to us following our inspection showed as of the end of November 2022, the service had an overall vacancy rate of 23.6%. This included 8.7% for consultants and 25% for registrars. Junior doctor positions had been over-recruited by 2 full time equivalent staff members. Medical staff told us there were sometimes gaps in the medical staff rota for middle grade doctors, however,

these were generally filled. The service mitigated staffing gaps by using bank and agency to fill shifts. Data provided to us following our inspection showed less than 1% of medical shifts were unfilled and the overall rate had significantly reduced over the 12 months prior to our inspection and was at 0% in November 2022. However, during our inspection we found there were sometimes delays in patients undergoing a senior review and being reviewed by a consultant upon admission. For example, in 6 out of 10 medical records we checked, the first consultant review was over 12 hours from time of admission. Furthermore, in 7 cases time to senior review was over 60 minutes. Senior review times varied from 60 minutes to 10 hours. The service did not routinely monitor or audit waiting times for children to have a senior and consultant review, therefore, they did not have oversight of whether the medical establishment was adequate.

Medical staffing levels out of normal working hours were not always sufficient to keep children and young people safe. Medical staff told us out of hours cover including evenings, weekends and nights was stretched as there had only been 1 registrar to cover the service. This impacted their ability to see patients in a timely manner and increased pressure on junior doctors. Recent incidents that had occurred, identified a potential risk of harm if more than 1 emergency was to happen at the same time as there was only 1 middle grade doctor on duty to cover the service. This was also cited as a risk on the service risk register. Incidents we reviewed following our inspection identified the risk of potential harm from having only 1 middle grade doctor on shift out of hours. Managers told us a twilight registrar had been added to the rota to support staff at busier times following review of medical staffing in relation to a recent incident. The service had recently recruited to 3 registrar positions and bank and agency were used to fill shifts. The service continued to advertise for middle grade positions. A medical escalation policy had recently been produced so that staff knew what to do should they not be able to get hold of the on-call doctor.

The service had reducing turnover rates for medical staff. Data provided to us following our inspection showed the average turnover rate from June to October 2022 was 7.9%.

Sickness rates for medical staff were low. Data provided to us following our inspection showed the average sickness rate for medical staff from June to November 2022 was 2.2%.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service used locums who were known to the service.

Records

Records were not stored securely. Records were up to date, but patient assessments were not fully completed.

Records were not always stored securely. Throughout our inspection we observed patient records and medicine charts being left unattended at nursing stations. Medical record trolleys were left unlocked and open when unattended. We observed a smart card left unattended in a computer. This meant records were accessible to unauthorised persons.

Patient notes were not always comprehensive, but all staff could access them easily. Records were a combination of electronic and paper records. The combination of records sometimes led to inconsistent recording. For example, we found safeguarding information was recorded on an electronic system and in paper records. However, we found the information was not always consistent and led to some gaps in recording of safeguarding concerns.

Tools and templates were available for staff to use to aid their assessment of patients, however, we found they were not fully completed in any of the 14 records we reviewed. For example, key information was sometimes missing in relation to their safeguarding status and fluid intake and hydration scores. Where sections were not completed, there was no rationale to document why they had not been completed.

Services for children and young people

Following our inspection, the service advised us they had added safe storage of records to daily manager checks to improve compliance with information governance policies and procedures.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes when storing medicines. During our inspection we checked the medicine room on Skylark ward. The room was found to be secure with key card access only by authorised persons. All medicines cupboards and fridges were locked. The room was clean and tidy, and medicines were found to be well organised and easy to find. We checked a random selection of 10 stock medicines, and all were in good condition and in date. Controlled Drugs (CD) were securely stored. A CD record book was in place, and we saw evidence of daily checks being undertaken of CDs as well as regular pharmacy checks. We checked 5 CDs and found them to be in good condition, in date and all accounted for in the CD book.

In the neonatal unit, learning had been implemented following a recent medicine incident involving the administration of adrenaline. Emergency medicines had been reviewed against the trust wide resuscitation policy. All medicines used in an emergency were placed in a red grab box which was easily identifiable. The medicines in the boxes were regularly checked to ensure the required doses of adrenaline were correct for use in emergencies. Drugs not required in an emergency were separated out to reduce the risk of a medication error.

However, during our inspection we also found the trust medicines management policies were not always effectively followed. We found:

- Out of date adrenaline on an emergency trolley on Skylark ward. We found a sealed bag with an expiry date of October 2022. In the bag contained 8 Adrenaline injections 1:10,000. Weekly checks of the trolley had been undertaken and staff had documented checking the content on the day of our inspection. This meant there was a risk a patient could be administered out of date medicines. Furthermore, systems and processes in place to check the safe storage and use of medicines were ineffective. This was escalated at the time of our inspection. Managers took immediate action to remove the medicines and check all other emergency medicines.
- A patient's own medicines which included a controlled drug were not recorded or stored securely at the time of our inspection. This is not in line with the trust medicines code which states patient own medicines should be locked in a medicine cabinet. Furthermore, before a patient's own medicines can be administered, they should be checked to ensure they are clearly labelled and of sufficient quality to be administered.
- An emergency neonates' trolley on Skylark ward, containing emergency medicines and equipment that could expose people to harm was left unlocked and unattended. This was located in a quieter location at the end of the ward. We escalated this to staff, including managers and were concerned staff lacked situational awareness of the risk. Staff considered the trolley was open for a reason as they were in the process of replacing equipment. This was escalated to managers and when we checked later during our inspection the trolley had been locked.

Following our inspection, the trust provided assurance of immediate action taken to improve safe storage. Trust wide learning had been sent out to staff through a patient safety newsletter and an informative video included to demonstrate the use and storage of adrenaline in emergency trolleys. Weekly audits of resuscitation trolleys and patients own medicines had been implemented to identify non-compliance with policy to improve practice.

Services for children and young people

Staff did not always follow systems and processes to prescribe, administer and record medicines safely. During our inspection we observed staff following appropriate procedures in administering medicines. We saw 2 staff administering medicines which required a staff member to observe or countersign to confirm the medicine had been given correctly. We reviewed 10 medicine charts and found where a medicine could not be administered, in general staff used a number on the medicine chart to indicate the reason the medicine was not given. However, we also found:

- Weights were not recorded in 6 records we reviewed.
- Allergies were recorded in most medicine records, however, the sensitivity status was not always signed and dated.
- Two patients who brought in their own medicines did not have them recorded on their medicine charts.
- Four patients regular medicines were recorded on the medicine chart. However, staff did not indicate on the medicine administration document on the following page which medicine they were administering as they did not record the name of the medicine on the administration record.
- In 1 record, medicines prescribed as and when needed were recorded in the patient's regular medicines section incorrectly.
- In 6 records where the patient required oxygen, only 5 medicine charts demonstrated oxygen had been clearly prescribed. In 2 of these cases, oxygen had been added to the prescription chart, but it had not been fully completed as the flow rate and ongoing administration had not been recorded. Furthermore, care plans did not always include detail of personalised oxygen saturation levels or required levels of oxygen. For example, a patient was admitted for oxygen therapy. The airway and breathing care plan was completed on admission to Skylark ward. Staff indicated which action was required from a list. However, staff did not record the baseline (low-high) oxygen saturations or record how oxygen would be administered and the percentage volume it should be set at.
- A medicine chart where lorazepam and haloperidol had been administered for the purpose of rapid tranquilisation, did not include maximum doses in line with best practice. Although we saw the medicines administered did not go over maximum doses over a 24-hour period.

During our inspection, staff told us they did not always administer medicines on time due to staffing levels and the increase in more complex patients impacting their time. Two records we reviewed showed delays in administration of antibiotics and some parents told us there were sometimes delays in their child receiving medicines.

As of end of October 2022, 90% of registered nurses on Skylark ward and 97% on the neonatal unit had completed medicines management training.

Following our inspection, we escalated our concerns to the trust who provided us with a detailed action plan to demonstrate how they intended to improve medicines management processes. A pharmacy audit of medication errors on the ward had been established and all errors were planned to be discussed at a trust wide doctors learning session and weekly during meetings with medical staff thereafter. Following our inspection, the consultant body communicated with medical staff their expectations that Oxygen therapy should be prescribed and that it would be audited moving forward.

Staff reviewed each patient’s medicine regularly and provided advice to patients and carers about their medicines. Ward and medical staff spoke to patients and their parents about their medicines, occasionally a pharmacist would also speak to patients. Parents were encouraged to be involved in administering medicines to their children**.**

Standard operating procedures were not in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. From June to December 2022, 1 patient had been administered rapid tranquilisation on

5 occasions. We were aware the service had on occasions considered using rapid tranquilisation where a young person had presented with an acute mental health condition, and they were at risk of harm to themselves. However, the trust did not have a policy and procedure in place to ensure the safe and appropriate rapid tranquilisation of young people. Following our inspection, the trust advised us a rapid tranquilisation guideline was being created with support from a local specialist paediatric mental health service. It was planned to be reviewed by the trust medicines committee in January 2023. Records we reviewed where rapid tranquilisation had been used showed, specialist advice had been sought before prescribing and administering rapid tranquilisation. We saw the least restrictive methods to manage the child's behaviour had been implemented, including oral sedation prior to administering rapid tranquilisation. Whilst the correct doses were administered, we did not see evidence of a rapid tranquilisation care plan to support the safe administration and ongoing monitoring.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Systems to implement lessons learnt and monitor their effectiveness overtime were not always effective in sustaining quality improvements.

Staff knew what incidents to report and how to report them. Staff understood their responsibilities to raise concerns and reported incidents and near misses in line with trust policy. Staff we spoke to understood what constituted an incident and required reporting. Staff could provide examples of incidents they had reported. For example, they told us they had reported staffing incidents and medication errors. The service had an electronic reporting system. Staff told us they would report incidents to the nurse in charge or manager on duty as well as on the electronic reporting system.

The service had no never events in the 12 months prior to our inspection. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Staff reported serious incidents clearly and in line with trust policy. There had been 5 serious incidents declared across children and young person's services in the 12 months prior to our inspection.

Most staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Serious incident reports we reviewed demonstrated duty of candour had been applied and the service had kept in contact with families throughout the investigation.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. Managers assigned incidents for investigation were supported by the trust wide patient safety team. We reviewed serious incident reports prior to our inspection and found these contained detail of the incident, root causes, contributory factors and learning for staff.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they received feedback from incidents they had reported. Managers produced monthly learning bulletins which contained a summary of incidents and learning points. Where immediate action was required, we saw managers sent an email summary to staff outlining the incident, any concerns and immediate actions required. For example, we saw a recent email in relation to safe sleeping expectations for babies. Staff we spoke to were able to tell us about recent learning shared from incidents. For example, staff described learning from a recent patient fall and described what changes they had made following the learning.

Services for children and young people

Opportunities to meet and discuss feedback from incidents was inconsistent. Staff told us they received feedback from incidents during handovers. Skylark ward had not undertaken any recent wards meetings; however, these were undertaken on the neonatal unit. Managers relied on staff accessing their emails to receive feedback from learning bulletins. However, some staff told us they did not have time to access their emails.

The neonatal unit contributed to perinatal mortality and morbidity meetings where specific incidents were discussed and learning identified. A monthly multi-disciplinary meeting was also held on the neonatal unit where learning was shared in relation to incidents.

There was evidence of changes being made as a result of learning from incidents. We saw the neonatal unit had implemented improved processes in relation to the safe storage and administration of emergency medicines following an incident where an incorrect dose was administered.

Following a serious incident which identified a delay in medical reviews and simultaneous emergencies as contributory factors, a medical escalation standard operating procedure had been produced to support nursing staff in escalating concerns should they have difficulties contacting the on-call doctor. This was aimed at preventing delays in medical escalation.

Learning from specific incidents was not always effectively embedded across the children and young people's services. For example, we found out of date adrenaline on the emergency trolley on Skylark ward. This raised concerns that following a serious incident involving adrenaline use on the neonatal unit, appropriate checks of medicines had not been undertaken. If the medicine had been checked in response to the incident on the neonatal unit, the out-of-date emergency medicines on Skylark ward were likely to have been identified sooner.

Systems to implement lessons learnt and monitor their effectiveness overtime were not always effective in sustaining quality improvements. For example, we found not all medical air sockets on Skylark ward had been capped off. This was identified as learning from a previous never event in 2021 and a previous national patient safety alert in 2016. There were no systems in place at the time of our inspection to monitor compliance against the patient safety alert or actions following the never event.

Managers debriefed and supported staff after any serious incident. Mortality and morbidity meetings and multidisciplinary meetings minutes from Skylark ward demonstrated managers had oversight to ensure the debrief process had been undertaken.

Is the service well-led?

Inadequate 

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. Key leadership roles had been vacant impacting effective leadership and oversight of quality and safety. Leaders were generally visible and approachable in the service for patients and staff.

The leadership team for children and young persons (CYP) services was newly formed following a recent change of management. The CYP service was overseen by a clinical director (CD), Head of Nursing (HoN) and operational lead. Both the CD and operational lead had only been in post for 2 to 3 months prior to our inspection. The HoN had been in

post less than a week at the time of our inspection, having been vacant since July 2022. Two matrons were employed who had oversight of specific parts of the service. For example, 1 matron led neonatal services and the other matron led the inpatient ward and the paediatric assessment unit. Band 7 ward managers had been recruited into each area to support the day-to-day management. Leaders in post had the ability to run the service. However, key leadership roles had been vacant impacting effective leadership and oversight of quality and performance.

CYP services reported into the family health division which was led by a mixture of medical, nursing and operational senior leaders. This included a chief of division, directors and deputy directors who contributed different skills to enable them to lead the service. The division was responsible for a wide portfolio of services, such as maternity and midwifery, gynaecology and pathology as well as CYP services.

Nursing leadership had been challenged in the absence of the HoN. Divisional deputy nursing directors had offered advice and support when required, however, some staff felt isolated and unsupported in the absence of a HoN. Local leaders acted up to fulfil some aspects of the HoN role, such as reporting and governance oversight. However, local leaders also had to increasingly undertake clinical duties to mitigate staffing gaps and high acuity which meant they struggled to maintain effective oversight of quality and safety day to day.

The service had key lead roles to support quality and safety including a named safeguarding doctor and nurse lead, a patient safety lead and mental health lead. However, the service did not have a paediatric sepsis lead; this role had been vacant since April 2022. Local leaders were unable to pick up this role as they did not have capacity. This meant the service did not have effective oversight of sepsis performance, quality and staff training. The division did not implement effective mitigations to address this risk in the absence of the paediatric sepsis lead nurse. Immediately following our inspection, the service had identified the trust sepsis team and pathway to excellence lead nurse to support with sepsis quality audits and ward-based support. This provided some assurance improvements in practice would be made in future.

The service had strengthened local leadership. For example, they recruited a consultant to work closely with the medical team to support quality improvements, education and training for medical staff across the service. All doctors we spoke to said they had received ongoing training and development. Furthermore, a band 7 ward manager position and practice development nurse had been added to the establishment and recruited into the neonatal unit to provide more consistent operational leadership and staff training. Skylark ward had identified a need to increase staffing levels to enable a nurse in charge to be supernumerary.

Multi-disciplinary leadership had improved. Managers told us work had been undertaken to improve working relationships between medical and nursing leaders. During our inspection we observed effective and positive working relationships between medical and nursing staff. Medical and nursing staff in charge worked well together to manage ward rounds. Lead consultants demonstrated a good level of understanding of both medical and nursing challenges and were able to explain how they would be addressed. We considered there to be a joined-up approach to improve the quality and safety of the service.

Most managers had completed a leadership or management course. The service had identified bespoke leadership training for CYP services and intended to roll this out to more junior nursing staff across the service.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. During our inspection we met with the senior leadership team and local leaders. They understood the current pressures facing the service and could describe what they needed to do to address them. Managers told us prior to our inspection

they had commenced a CYP project with several workstreams as they had identified concerns as a result of serious incidents and feedback from stakeholders. This included workstreams in relation to staff training and competency, staff health and wellbeing and governance. However, at the time of our inspection this had not yet been implemented although a project manager had been recruited to lead on the project.

Some staff but not all felt leaders were visible and approachable. During our inspection we observed managers and leaders were visible in clinical areas and observed them undertaking clinical activities to support staff and patients. Junior medical and middle grade medical staff described their seniors to be approachable, available and supportive. However, we received variable feedback regarding the visibility and support from nursing leaders. Some staff described leaders being approachable and supportive and others felt they did not fully understand the pressures staff were under and did not always feel listened to.

Vision and Strategy

The service had a business plan for what it wanted to achieve which included a strategy to turn it into action. The strategy was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood the plans in place. However, strategic monitoring of the strategy was inconsistent.

The family health division had an integrated business plan in place for 2022/23 which included a strategy and plan to develop CYP services. The service undertook an analysis of service strengths, weaknesses, opportunities and key threats. They used the outcome to form a list of objectives to enable the service to deliver divisional priorities. We found some of the priorities were aligned to concerns we identified during our inspection; however, they did not focus on sustainability of quality improvements overtime and how oversight would be managed in the absence of the HoN. The priorities included a redesign of the neonatal unit estate to improve patient safety and improve the number of skilled neonatal staff. It also included the recruiting a supernumerary nurse in charge on both Skylark ward and the neonatal unit, recruiting a sepsis and mental health specialist nurse, develop a digital process, improve allied health professional provision and improve collaboration across the system, to reduce readmissions. Not all these had been achieved at the time of the inspection, however, it was recognised some were impacted by the absence of a HoN and others had been delayed. For example, the development of the neonatal unit estate had not progressed, but the service was in the process of developing a business case.

The strategy was aligned to local plans in the wider health and social care economy to meet the needs of the local population. The trust had a group model approach with another acute hospital in Northamptonshire. The strategy outlined plans to develop a group model for CYP services including the development of shared paediatric pathways across Northamptonshire hospitals. The service worked with the local integrated care board in developing community and acute paediatric pathways with community services including children and adolescent mental health services. They aimed to develop a shared resource pool for allied health professionals.

The service had a CYP capacity and surge plan which had been signed off in November 2022. During our inspection we saw the capacity plan had been fully implemented for the first time as the service was under unprecedented demand. We saw there were increased ward rounds to ensure all patients were reviewed and discharged where appropriate. Elective surgery had been cancelled and the paediatric assessment unit had been temporarily closed to accommodate an increase in patients requiring an inpatient bed.

Oversight of strategic objectives was not always effective. Divisional governance and business meeting minutes we reviewed following our inspection from August to October 2022, did not demonstrate progress against delivery of strategic objectives was monitored or reviewed. Key risks to the service, such as staffing pressures, the neonatal unit environment and development of a digital approach had not progressed.

Services for children and young people

Staff we spoke to did not have an understanding of the divisional strategy but had an awareness of the CYP service pressures and understood the implementation of the capacity and surge plan.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. However, the staffing levels and acuity impacted staff ability to deliver high standards of care. The service provided opportunities for career development. The service did not always have an open culture where patients, their families and staff could raise concerns without fear.

Some but not all staff felt respected, supported and valued. We received variable feedback from staff. Most staff described being under significant pressure, particularly at the time of our inspection where the service was experiencing unprecedented demand. Medical staff we spoke to told us they felt supported and valued. Some nursing staff did not always feel their feedback was respected or listened too, resulting in them feeling demotivated. For example, staff told us they did not always feel they were supported in dealing with challenging behaviours. Furthermore, some staff felt there was unfairness in how shifts were allocated and did not always feel managers recognised their personal circumstances when planning the rota.

Staff were focused on the needs of patients receiving care. However, the staffing levels and acuity impacted staff ability to deliver high standards of care. Nursing staff we spoke to commented that the service was understaffed, and it impacted on their ability to provide an adequate level of care to patients. Some staff understood the challenges and considered managers were doing what they could and supported them at times of peak activity. However, more than 1 member of staff commented they had experienced work-related stress and did not feel supported by managers. More than 1 staff member told us they wanted to leave.

Not all staff felt positive and proud to work in the organisation. However, most staff were very passionate about their role as a registered healthcare professional in caring and treating children and young people. Whilst most staff commented on the pressures in their role, they described positive team working with colleagues of different professions. We observed respectful conversations take place between medical and nursing staff, demonstrating a collaborative approach to patient care and treatment.

The service provided opportunities for career development. Managers told us they struggled to recruit specialist children, young person and neonatal staff, therefore, had implemented a grow your own model. This had resulted in opportunities for staff of all grades to develop their skills and progress within their career. For example, the service had introduced nurse associates to provide health care assistants with opportunities to develop.

The service did not always have an open culture where patients, their families and staff could raise concerns. Some parents told us they were aware staff were very busy so did not always feedback concerns they had. Other parents commented staff were very nice and felt listened to when they had concerns about their child or wanted to raise a concern. Three parents we spoke to commented managers had been defensive and sometimes dismissive when raising concerns with them about their child's care and treatment. Two parents told us managers did not act on feedback they provided them in relation to cleanliness and communication.

During our inspection, we observed managers and staff in charge, sometimes lacked situational awareness of risk. Managers were not always receptive to feedback where we had identified concerns during our inspection. We recognised the service was under significant pressure on the days we inspected. Managers had competing priorities, however, we considered there was a lack of urgency to address some areas of concern we raised with them at the time. For example, in responding to 2 separate medicines management concerns we raised.

Managers felt confident they could escalate any concerns they had to their current senior managers. Some staff told us they felt able to raise concerns with their managers, but others did not feel comfortable to do this. Most staff we spoke to did not know who the freedom to speak up guardians were. We observed a freedom to speak up guardian presence on Skylark ward during our follow up inspection on 19 December 2022.

Following our inspection, the trust provided us with a plan to improve the culture with immediate effect. Listening events commenced on 30 December 2022 with staff to provide opportunities to feedback ideas and concerns. It was intended these would continue for a 3-month period. The trust freedom to speak up guardian planned to attend ward meetings over a 3-month period to educate staff about the importance of speaking up to keep patients safe. The trust also intended to implement a band 6 nurse in charge development programme to support them to effectively lead a shift, develop situational awareness and check points to listen to staff.

Governance

Leaders did not always operate effective governance processes, throughout the service. Trust wide deteriorating patients quality improvement plans were not embedded within children and young person's governance processes. Staff at all levels were clear about their roles and accountabilities but did not always have regular opportunities to meet, discuss and learn from the performance of the service.

Governance systems were not always effective in supporting the delivery of good quality and sustainable services. Areas of concern we identified during our inspection, were similar to those we identified during our previous inspection in 2017 and cited as themes through incidents and complaints we reviewed since then. Leaders did not have a robust oversight of the service at the time of our inspection to ensure the service was being effectively managed. We found limited progress had been made to improve the quality and safety of the service. For example, we found:

- During our previous inspection, the service was unable to meet Royal College of Paediatrics and Child Health (RCPCH) 'High Dependency Care for Children safe staffing levels. This continued to be a risk, despite managers telling us the demand for high dependency care had significantly increased since our previous inspection. We did not see evidence of actions having been taken to address the staffing levels in the high dependency unit.
- During our previous inspection we found 66% of neonatal nurses had completed their post registration qualification, which did not meet the British Association of Perinatal Medicine (BAPM) of 70%. At the time we were told there were additional staff completing the qualification. During this inspection, we found compliance since then had deteriorated.
- Completion of patient risk assessments was identified as a concern during our previous inspection, and we found this continued to be a concern during our current inspection.
- Fluid balance monitoring was identified as a concern during our previous inspection and also identified as a concern through a serious incident. This continued to be a concern during our current inspection.
- During our previous inspection, we found Skylark ward did not have ward meetings in place, which they planned to restart following our inspection. However, we did not find evidence during our inspection, ward meetings were consistently undertaken on Skylark ward.
- Repeated non-compliance with a national patient safety alert in relation to the safe use of medical air was identified during our inspection. This was of significant concern as the patient safety alert was issued in 2016 requiring all trusts to take action. There had been a never event on Skylark ward in 2021 as a result of unsafe use of medical air when the ward was temporarily an adult respiratory ward during the COVID-19 pandemic. However, during our inspection we found there continued to be non-compliance with the national patient safety alert.

Services for children and young people

Governance and management at all levels did not always function effectively and interact with each other appropriately. We found trust wide patient safety initiatives were not effectively implemented within the division to improve patient safety. In August 2022, the trust implemented deteriorating patient improvement plan. The improvement plan aimed to drive improvements in the identification and management of deteriorating patients within the trust. This included but was not limited to improving the monitoring of deteriorating patients as well as sepsis identification and treatment. During our inspection, we did not see evidence that CYP services implemented the quality improvements into the service. Divisional governance meetings did not demonstrate leaders implemented and monitored these quality improvements. Furthermore, we were aware sepsis audits had not been undertaken from April to October 2022. Managers told us this was because the sepsis lead nurse role was vacant. This meant there was no ownership, oversight and monitoring of sepsis performance to identify poor practice, learning and drive improvements to ensure patients were safe. Incidents we reviewed prior to our inspection had identified non-compliance with sepsis screening as a contributory factor or root cause. During our inspection we found non-compliance with sepsis pathways. We were concerned the lack of governance and oversight from service and divisional leaders exposed patients to ongoing risk of harm.

Nursing representation at divisional governance meetings was inconsistent. Governance meeting minutes we reviewed from September to November 2022 showed a lack of representation from CYP managers. Matrons stepped up in the absence of the HoN to complete monthly '4 box reports' for the integrated business and governance meeting. These included an overview of highlights and exceptions in relation to risks, incidents, performance and staffing. However, we did not see evidence of appropriate scrutiny of service quality and performance or evidence to demonstrate how divisional leads were managing risks and areas for improvement.

We were therefore not assured the leadership and governance arrangements in place within the service and the family health division enabled effective oversight and monitoring to ensure service improvement plans previously in place were fully implemented and improvements were sustained overtime. Furthermore, we were not assured the trust board received a comprehensive overview of the service performance as this was not shared at divisional level.

Not all staff had regular opportunities to meet, discuss and learn from the performance of the service. The neonatal unit held monthly staff meetings where information around quality, performance, incidents, learning, risk and service developments was discussed. However, Skylark ward had stopped monthly team meeting. Managers told us service updates and shared learning was disseminated by email, handover and through a newsletter. However, during our inspection, staff told us they rarely accessed their emails during their shift as they were very busy. Therefore, we were not assured systems for disseminating information was always effective.

CYP services represented at the monthly trust safeguarding steering group. This included the paediatric named safeguarding consultant and a nursing lead. The head of nursing or matron produced a monthly activity report to feed into this meeting. For example, they reported on training compliance, patients admitted on a self-harm pathway, mental health referrals, time to mental health review, patients requiring enhanced supervision, safeguarding referrals made and other safeguarding incidents. This was an activity dashboard and minutes of the meeting we reviewed for October and November 2022 demonstrated discussions held around specific high-risk cases.

Following our inspection, the service provided an action plan outlining some areas of improvement in response to our warning notice. The trust intended to revise and update a service assurance template to cover mandated elements of quality. This included learning from incidents, patient experience, risk management, quality audit compliance, and infection, prevention and control standards. The service told us the assurance template would be completed by directorate leads and submitted to monthly division governance meeting for oversight.

Services for children and young people

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. Risk assessments to continually identify ward based risks were not always effective. Leaders identified and escalated relevant risks. However, actions to reduce their impact were not always in place or effective. They had plans to cope with unexpected events.

Processes in place for monitoring service safety, performance and quality were not always effective. Managers completed a programme of internal audit to monitor quality and operational processes. For example, audits measures included assessing standards for documentation, the environment, infection prevention and control, risk assessments, fluid balance monitoring and medicines management. However, we were not assured these audits were always effective in identifying non-compliance, based on what we saw during our inspection. For example, we found nursing assessments were not fully completed in any record we reviewed on Skylark ward. However, a documentation audit undertaken on 30 November 2022 stated 9 out of 10 records reviewed had a full nursing assessment accurately completed. Furthermore, we found patients own medicines were not always stored in line with trust policy. However, this was not checked through routine audits.

We found not all children received medical reviews in line with RCPCH guidance. Managers told us they did not routinely monitor or audit waiting times for children to have a medical review. Timeliness of medical reviews had been identified as a concern in a serious incident we had reviewed prior to our inspection. We also found some delays in medical staff reviewing patients during our inspection. This meant the trust did not have full oversight or assurance against this measure.

Environmental risk assessments were not consistently completed. Following our inspection, we requested environmental risk assessments including ligature risk assessments. We were not sent any and advised by managers the risks were included on the risk register. The most recent annual ligature risk assessment had been undertaken in October 2021 when the ward was temporarily used as a respiratory ward for adults during the COVID-19 pandemic. This meant at the time of the inspection, the service did not have an up-to-date ligature risk assessment completed and may not have reflected risk accurately. This was of significant concern as the service regularly admitted patients with acute mental health conditions and patients who were at risk of self-harm. We were not assured the service took sufficient action to continuously assess this risk and divisional leaders did not have oversight of this. Following our inspection, the trust provided assurance they have undertaken a ligature risk assessment on 11 January 2023.

Audits did not always impact on making improvements. During our inspection we identified poor compliance with for example, the undertaking of patient risk assessments, timeliness of patient observations, sepsis screening and pathways, environmental risks, medicines management and infection, prevention and control. Some of these concerns had been identified during our previous inspection in 2017 and identified as a theme in complaints and incidents. For example, we found:

- Equipment was not always clean, and the service did not have a process in place to let staff know if equipment had been cleaned. This was cited as a repeated concern in the service 100 step audits we reviewed from June to November 2022, yet we found no evidence of action taken to address this and the risk continued.
- We found evidence there was dust on cots. Dust found on equipment in patient bays and cubicles was a repeated theme identified in 100 step audits, however, there was no evidence of actions being taken to improve this and the risk continued.

- Emergency trolley safety checks were not always effective. During our inspection we found out of date emergency medicines from October 2022, yet these had not been identified through medicines management audits and daily/ weekly checks.
- The service undertook deteriorating patient audits monthly. Audits assessed compliance against observations, escalation of deteriorating patient and use of a Situation, Background Assessment Recommendation (SBAR) communication tool in escalating a patient. Ten audits undertaken from November 2021 to October 2022, showed an average 95% compliance with audit standards. Based on what we found during our inspection, we were not assured the audits were robust in identifying compliance with PEWS standards. Furthermore, we did not see evidence of an SBAR communication tool being used in any record we reviewed where a patient was escalated.
- We found poor compliance with sepsis screening and action tools. The service did not have a fully embedded audit to measure performance against sepsis screening and treatment standards in paediatrics.
- Fluid balance monitoring had been identified as a concern following a previous serious incident, external reviews of the service and during our inspection we continued to find variable compliance with fluid balance monitoring.

This meant processes to monitor service compliance against set measures were not always effective in driving quality and performance improvements and sustaining these over time.

Leaders identified and escalated some but not all risks. We found limited evidence that areas for improvement identified following routine audits were shared with staff so improvements could be made. For example, we did not see evidence audit outcomes were consistently discussed or monitored during divisional and service governance meetings. Furthermore, we did not see audits were routinely discussed through team meetings or shared in team newsletters.

Performance oversight processes were not consistently embedded across the service. The neonatal service produced a dashboard on performance which was shared in readiness for the integrated business and governance meeting. This provided senior leaders with assurance internal and national quality and safety indicators were being met and areas for improvement. However, managers told us the paediatric quality and performance dashboard previously in place, had not been produced and submitted to the meeting for some time. Service and divisional leaders told us this was something they intended to implement again. This meant the service did not have an established mechanism to review the overall quality and safety performance of the service. Furthermore, this meant the trust board did not have full oversight of quality and safety within the service.

Service risk registers were in place, monitored and managers understood the service risks. There were 21 open risks for Skylark ward which included the paediatric assessment unit. Two of which were rated as a significant risk in relation to a surge in demand and an increase in acuity meaning the service may not be able to meet staffing ratios. There were a further 7 high risk, 3 moderate and 10 low risk. There were 20 open risks on the neonatal risk register which included 2 significant risks in relation to the neonatal unit environment and the number of qualified in speciality trained staff. There were a further 4 high risk, 8 moderate risk and 6 low risk. The risk register provided a detailed outline of the risks, controls, gaps in control, responsible persons, actions required and review dates. However, the date the risk was added was not included.

The risks were monitored through divisional governance meetings and neonatal governance meetings. Mitigating actions were listed to reduce risks however, these were not specifically allocated or dated therefore, it was not possible to tell from the risk register if these actions were being delivered at the time of inspection. Despite this, we saw managers including the divisional leadership team, matrons and ward manager had a good understanding on active risks to the service at the time of inspection and were able to talk about how these were being specifically mitigated.

Not all risks on the risk register were effectively mitigated. For example, there was a risk in relation to not having a dedicated paediatric sepsis nurse and the service not being able to undertake quality audits. The service did not undertake any sepsis audits from April to October 2022. During our inspection we found poor compliance with sepsis identification and management. We did not see evidence there were any actions in place on the risk register to ensure the risks were mitigated. Furthermore, control measures were not always up to date. For example, a control measure for the risk that there was not always a nurse with advanced life support on duty was 'all paediatric consultants and middle grade paediatric doctors have up to date qualification in advanced life support'. However, data provided to us following our inspection showed not all consultants were up to date with this level of life support.

Day to day identification and management of risk was done using a ward co-ordinator daily check sheet on Skylark ward. These provided an oversight of activity, acuity, staffing and risks requiring monitoring. We reviewed the checklists completed from 5 to 11 December 2022 and found these were not always fully completed to demonstrate oversight of risks and that checks had been completed. During our inspection we observed the nurse in charge to be extremely busy in ward rounds for most of the day and supporting on the ward.

Information Management

The service did not always collect reliable data and analysed it. Staff could find the data they needed, but not always in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Digital improvements within children and young person services had been improved but timescales for further improvements were not in place. Leaders told us there were plans to align blood gas machines to trust wide systems and add patient assessments to electronic systems. However, there were no confirmed timescales at the time of our inspection for these developments.

Information technology systems were not always used effectively to monitor and improve the quality of care. For example, at the time of our inspection ward-based point of care blood gas machines were not linked to electronic patient records. This meant there was a risk the results could be accidentally placed in the wrong patient record and impact clinical decision making for the wrong child. For example, we saw '11111' in a record we reviewed which did not correspond with the individual patient.

The service had several systems for recording safeguarding information which did not support staff to effectively assess and document the risks. For example, safeguarding risks were recorded on an electronic system, in the paediatric emergency department assessment, in the ward nursing records and centrally with the trust wide safeguarding team. There was a potential risk of missing a child that needed to be safeguarded because the 2 sets of records did not correlate. The hybrid system of record keeping posed a safety risk as documentation was inconsistent across them both. The service systems and processes in place did not support the effective oversight of compliance with policy as there were multiple systems for recording information which meant there was a risk information could be missed.

The service added patient observations and Paediatric Early Warning Score (PEWS) to electronic systems. We saw these systems were used effectively to add patient observations immediately at the time they were taken. We saw electronic patient overview systems were used effectively by nursing and medical staff to review each patient during ward rounds.

Services for children and young people

Electronic PEWS monitoring systems were not always used effectively to provide oversight of deteriorating patients. Where a patient PEWS showed there were signs of deterioration, the action taken was not accurately recorded. For example, in general staff selected 'no' to have the concerns been escalated. When we reviewed the records to check, in general patients had been escalated but it had not been recorded on the electronic system. This meant electronic records did not provide nursing and medical staff in charge a snapshot of whether a patient had been escalated.

Notifications were submitted to external organisations as required.

Staff attended daily handovers with their colleagues and the named nurses of patients they were due to support each day. This provided them with the information they required to meet the specific needs of each patient.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Children and young person's services

- The service must ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; pressure care, nutrition, hydration, management of the deteriorating patient, patients with complex needs and patients admitted following self-harm incidents. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The service must ensure temperatures are always taken when monitoring vital signs and there are enough thermometers to enable staff to complete a full set of observations in a timely manner. Regulation 12 (1)(2)(a)(b)(f): Safe care and treatment.
- The service must ensure effective systems are in place and fully implemented to assess and treat patients at risk of sepsis in a timely manner. This includes but is not limited to ensuring patients undergo a timely assessment to determine their risk of sepsis, and patients at risk receive a medical review, diagnostics and treatment within a timely manner. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The service must ensure effective systems are in place and fully implemented to prevent the risk of dehydration or fluid overload by monitoring fluid input and output. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The service must ensure the proper and safe management of medicines. This includes but is not limited to oxygen therapy; management of patients own medicines; and recording in medicine charts. Regulation 12 (1)(2)(g): Safe care and treatment.
- The service must ensure effective systems and processes are fully embedded to prevent, detect and control the spread of infection. This includes but is not limited to cleanliness of equipment and the environment; barrier nursing of patients with communicable diseases; and ensuring the risk of infection is assessed and monitored for patients with a cannula in place. Regulation 12 (1)(2)(h): Safe care and treatment.

Services for children and young people

- The service must ensure systems and processes for checking nationally approved child protection information sharing systems, assessing a patient's social background and documenting actions taken to safeguarding a child are fully embedded. Regulation 13 (1)(2): Safeguarding service users from abuse and improper treatment.
- The service must ensure systems and processes are in place to ensure learning from patient safety incidents is embedded across the service and improvements are sustained overtime. Regulation 17 (1)(2)(a): Good governance.
- The service must ensure systems and processes to check medical air ports are covered when not in use to prevent accidental connection to air are in place. Regulation 17 (1)(2)(a): Good governance.
- The service must ensure processes in place to check equipment and medicines on emergency trolleys are robustly undertaken. Regulation 17 (1)(2)(a): Good governance.
- The service must ensure processes are in place to regularly assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. This includes but is not limited to undertaking regular environmental and ligature risk assessments and taking action to mitigate risks. 17 (1)(2)(b): Good governance.
- The service must ensure effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care provided. This includes but is not limited to processes to identify where quality and/or safety are being compromised; quality and safety audits; and incident investigation oversight processes including quality improvement oversight. Regulation 17 (1)(2)(a)(b): Good governance.
- The service must ensure all patient records are kept secure at all times and only accessed by authorised people. Regulation 17 (2)(c) Good governance.
- The service must ensure medical staff are up to date with mandatory training in key skills. This includes safeguarding adults and children training to the appropriate level. Regulation 18 (1)(2)(c) Staffing.
- The service must ensure all relevant staff are trained to the highest-level of life support. This includes ensuring the Paediatric Assessment Unit has a staff member on duty trained in Advanced Paediatric Life Support in line with the Royal College of Nursing safe staffing guidelines which states a Paediatric Assessment Unit should have Advanced Paediatric Life Support trained staff. Regulation 18 (1)(2)(c): Staffing.
- The service must ensure medical staffing establishment and cover arrangements enable Royal College of Paediatrics and Child Health standards to be met. This includes but is not limited to ensuring patients are assessed and reviewed by a suitably trained doctor within appropriate timescales; there is sufficient cover to manage paediatric emergencies; and out of hours medical cover is planned to reflect the activity and acuity of the service so that patients are kept safe. Regulation 18 (1): Staffing.
- The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff in all areas of children and young person's services. This includes but is not limited to: ensuring the nurse staffing levels in the high dependency unit are compliant with the Royal College of Paediatrics and Child Health 'High Dependency Care for Children – Time to Move On' (October 2014); ensuring the neonatal unit has sufficient numbers of neonatal nurses qualified in speciality in line with British Association of Perinatal Medicine standards; and the registered nurse to patient ratio is reflective of acuity and meets Royal College of Nursing safer staffing guidance for paediatric wards. Regulation 18 (1): Staffing.
- The service must ensure all temporary staff are provided with an induction and are competent to work within a paediatric setting. Regulation 18 (1): Staffing.

Action the trust SHOULD take to improve:

Services for children and young people

Children and young persons services

- The service should ensure that relevant staff are provided with training on recognising and responding to children and young people with mental health needs, a learning disability and autism. This includes but is not limited to de-escalation training to safely support the management of patients with challenging behaviours. Regulation 18 (1): Staffing.
- The service should ensure a rapid tranquilisation policy and procedure is in place to support staff in the safe administration. This includes but is not limited to ensuring rapid tranquilisation care plans are personalised and documented and appropriate physical observations are undertaken. Regulation 12 (1)(2)(g): Safe care and treatment.
- The service should consider implementing a standard operating procedure within the paediatric assessment unit.
- The service should consider reviewing the functionality of the electronic patient record to record where patients have been escalated where required.
- The service should consider reviewing its processes for seeking staff feedback.

Urgent and emergency services

Requires Improvement ● →←

We rated it as requires improvement because:

- There were not enough nursing staff trained to the highest level of life support. Not all staff had completed mandatory safeguarding training. Systems and processes to check nationally approved child protection information sharing systems were in place but not fully embedded. Safeguarding assessments were not fully completed on admission. Equipment was not always cleaned between use. The design, maintenance, and use of facilities and premises did not keep patients safe. Risks to patients were not always assessed appropriately. Nursing risk assessments and safety checklists were not always completed. The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and were not easily available to all staff providing care. Medicines were not always administered on time. The service did not always manage patient safety incidents well.
- The service did not have a vision for what it wanted to achieve. Paediatric emergency department governance processes were improving but had not yet fully integrated into the urgent care service. Staff did not always feel respected, supported and valued. The staffing levels, acuity and environment impacted staff ability to deliver high standards of care. Staff were not always clear about their roles and accountabilities. Leaders and staff did not always actively and openly engage with patients and staff. Processes to improve quality and performance were not yet embedded into the paediatric emergency department. The service did not always collect reliable data.

However:

- Most nursing staff were up to date with mandatory training. Managers regularly reviewed staffing levels. The service had enough medical staff working specifically in paediatric emergency department to keep patients safe from avoidable harm and to provide the right care and treatment. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Leaders in place had only recently taken over the service but were fully aware of the risks and improvements that were required. Staff were focused on the needs of patients receiving care. Staff identified and escalated relevant risks and issues and identified actions to reduce their impact. All staff were committed to continually improving services.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training. However, not all staff had completed it.

Urgent and emergency services

Registered nursing (RN) staff received and kept up to date with their mandatory training. Following our inspection, the service provided us with a breakdown of mandatory training compliance data as of the end of October 2022. RNs were compliant with the trust 85% target in all 13 modules, ranging from 85 to 100% compliance. Furthermore, 100% of non-registered nursing staff had completed all 13 mandatory training modules.

Following our inspection, we requested mandatory training compliance data for medical staff working within the PED. The service did not provide this information. We requested medical staff mandatory training compliance. However, the trust informed us it was not broken down into Paediatric Emergency Department (PED), therefore our request was not provided. This meant we did not have assurance that medical staff working within the PED were up to date with their mandatory training.

Mandatory training was comprehensive and met the needs of children, young people and staff. Training modules included key areas such as: health and safety, fire safety, manual handling, infection prevention and control, equality and diversity, information governance, sepsis and paediatric basic life support. Training was a combination of face to face and online learning.

Compliance to the highest level of life support training was not achieved for RN staff. Data provided by the trust showed 6 out of 20 (30%) RNs had completed Advanced Paediatric Life Support (APLS). Furthermore, 12 out of 20 (60%) RNs had completed Paediatric Immediate Life Support (PILS) and 92% had completed paediatric basic life support training. Following our inspection, the service told us there was a plan to increase the number of staff with APLS or equivalent and PILS by the end of January 2023 to achieve 85% compliance.

Specific PED staff training and competency assessments were overdue. A competency assessment framework was in place to ensure RNs working within PED had the competencies required to care for Children and Young People (CYP) attending the department. However, the training and competency assessment process was overdue. The service could not be assured all staff working in the department had the relevant competencies. This was cited as a risk on the service risk register and we saw there was an action to review the framework by January 2023 to ensure it met national guidelines and Royal College Paediatrics Child Health standards.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff had access to training on how to recognise and report abuse, however, not all staff had completed it. Systems and processes to check nationally approved child protection information sharing systems were in place but not fully embedded. Safeguarding assessments were not fully completed on admission.

Nursing staff received training specific for their role on how to recognise and report abuse.

However, only 76% of staff completed safeguarding children level 2 training and 66% of staff had completed their safeguarding children level 3 training. The service did not provide us data to demonstrate medical staff had received the appropriate level of safeguarding training.

Urgent and emergency services

Staff did not always follow safe procedures for children visiting the emergency department. We reviewed 4 children's safeguarding records and found patients' social histories including safeguarding risks were not always assessed in the PED. We found the formal process around safeguarding referrals and documentation was not embedded to enable staff working in PED to effectively assess, record and mitigate the risks associated with children attending PED. This did not assure us that children attending PED were safeguarded and followed up robustly.

For example, a 17-year-old who presented to PED with an injury chose to be seen on an adult pathway, however, decided to self-discharge after 5 hours of waiting. We did not find any evidence a safeguarding checklist had been completed, that the family background had been recorded and there was no evidence electronic records had been updated. We found the patient did not sign their self-discharge documentation and we did not find any follow up care had been undertaken for this patient. Another record we reviewed did not demonstrate appropriate safeguarding checks had been completed or parental responsibility had been documented. This was of concern as the child was 13 months old with 6 previous attendances.

Safeguarding information was recorded on both paper and electronic patient records. We found the hybrid system of record keeping posed a safety risk as the information was inconsistent in records were reviewed. This meant there was a potential risk of missing a child that needed to be safeguarded because the 2 sets of records did not correlate.

Staff we spoke within the PED told us they did not have time to complete patient documentation. They told us that seeing the patient was more important, and that documentation was lacking because of the additional pressure on staff and the demand of service.

We found no voice of the child in any electronic records that we reviewed. The policy for children who did not attend their appointment (formally known as DNA Policy for children) was out of date as of September 2022.

Processes were in place for staff to follow if parents or carers left with the child prior to being seen. The process directed staff to a suitable outcome should they be able to contact the parent or carer. However, if there were safeguarding concerns and staff could not contact the parents or carers, the process only required staff to update the discharge letter and trust electronic system.

There was no reference to staff escalating their concerns to the trust safeguarding team and/or local authority. However, data received from the trust after the inspection, showed us evidence of the trust completing regular documentation audits around child protection information sharing (CPIS). In September 2022, 491 records were reviewed, 98% of records were completed, 0.6% were not completed and 0.6% were not applicable. In October 2022, 544 records were reviewed, 97% of records were completed, 0.6% were not completed and 2.0% were not applicable. In November 2022, 662 of records were reviewed, 97% of records were completed, 0.3% were not completed and 2.9% were not applicable.

CPIS assists information sharing between the local authority and health. CPIS identifies and safeguards unborn babies and children who are subject to a local authority child protection plan when attending unscheduled healthcare settings across England.

We reviewed the trust's December 2022 safeguarding steering group meeting minutes and found that safeguarding within PED was high on the agenda, and one of the main areas to monitor closely. The aim of the meeting was to provide trust assurance regarding safeguarding children arrangements and to follow the strategy for excellence in safeguarding.

The recommendations from the meeting were that the staff needed to be vigilant regarding any safeguarding concerns and ensure that they were adhering to policy and processes. Compliance of mandatory training was essential, and that staff should be able to identify concerns and escalate as required. The safeguarding strategy required embedding in practice, however, acknowledged that the service and trust were under extreme pressures.

Following our inspection, the trust provided us with their children and young person services improvement plan. By the end of January 2023, the trust intended to introduce a set of minimum standards for documenting interactions with safeguarding leads and trust wide team in patient records. A safeguarding documentation standards audit had been implemented following our inspection to improve practice. This was planned to be reported to the trust wide safeguarding steering group.

Cleanliness, infection control and hygiene

The service sometimes controlled infection risk well. Staff used equipment but did not always use control measures around cleaning of equipment use to ensure safety of patients.

All areas appeared to be clean and had suitable furnishings. However, cleaning records were not always kept up to date, which did not demonstrate that all areas were cleaned regularly. We reviewed PED 100 steps cleaning inspection report in November 2022, which showed a score of 64% compliance. Main areas with a low score were the kitchen, bays/bed space and nursing equipment. We observed that staff did not always clean equipment, such as blood pressure monitors, after patient contact. Equipment was not labelled to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff adhered to the World Health Organisation's (WHO) 5 moments for hand hygiene. We observed staff completing hand hygiene and hand wash basins were available along with hand sanitising gel. We reviewed the PED's latest hand hygiene audits in November 2022, which showed a compliance rate of 85%.

Environment and equipment

The design, maintenance, and use of facilities and premises did not keep patients safe.

The space and capacity of the department was not sufficient to manage the volume of attendances, particularly at times of increased demand. At the time of our inspection the service was under unprecedented demand and attendances to the department had significantly increased. We observed corridors and walkways were obstructed with children and their parents/carers waiting to be seen. In the event of an emergency this had the potential to block access and impact staff ability to effectively care for and treat the deteriorating patient. This was recorded as a high-level risk on the department risk register.

The layout of the department meant staff did not have sight of patients in the department at all times. For example, some parts of the waiting room were not in line of sight of staff at the nurses' station. The doors leading to the designated red area also meant there was a restricted view of children in the department. Furthermore, at the time of our inspection, the volume of patients and their parents/carers in the waiting room and corridors meant staff could not see all patients. This meant there was a potential risk of harm of staff not identifying a deteriorating patient in the waiting area or areas of the department not in line of sight of staff. The environment and lack of visibility of patients in waiting areas and cubicles was highlighted as a risk on the service risk register.

Urgent and emergency services

Processes to triage and review patients in an organised way were not always effective. Flow throughout the department was restricted by the increase in demand but also the staffing levels and limited rooms to triage, assess and treat patients awaiting admission. Staff in charge tried their best to manage the volume of patients, however, we did not observe there to be an effective system to stream patients to a suitable location within the department or wider CYP service.

The service did not always have enough suitable equipment to keep patients safe. Staff told us there was a shortage of clinical equipment to measure patients' vital signs, such as blood pressure monitors and thermometers. During our inspection we observed staff looking for equipment and waiting for equipment to be available. This meant there were sometimes delays in patients' observations being monitored as a result of limited access to equipment.

The department had a limited number of bed spaces available with piped gases, such as oxygen, medical air and suction. Nine bed spaces were available, 5 of which had piped oxygen. Staff told us portable oxygen cylinders were stored under each trolley in the 4 bed spaces without piped oxygen and medical air supply. Patients who required respiratory support were moved to rooms with piped gases. However, staff told us there was a significant increase in attendances and increase in patients requiring respiratory support. Whilst there was portable oxygen stored on trolleys, daily checks of oxygen cylinders were not always undertaken as part of the service daily safety checks. This was included as a risk on the service risk register.

The department did not have a blood gas analyser. Where urgent blood gases were required for an unwell child, staff had to take the specimen to the main emergency department, Skylark ward or to the pathology department. This meant there was a potential delay in obtaining results and initiating treatment.

Prior to our inspection managers had already identified concerns with the capacity and layout of the department and had agreed a plan to relocate the department. Following our inspection, the service provided us with an action plan outlining plans to relocate the service to an area close to the adult emergency department by the end of January 2023. The area had a larger footprint and waiting area to accommodate an increase in attendances. Managers told us the new location would provide an improved visual oversight by the nurse in charge and staff working in PED.

There was appropriate emergency equipment, such as resuscitation equipment. Daily checks were undertaken to confirm emergency equipment was in place. However, we found some days where no checks were completed. We checked a range of consumable items from the resuscitation equipment and noted all items were sterile and in-date.

Staff disposed of clinical waste safely. There were systems to ensure clinical waste, such as sharps, was appropriately disposed of. Clinical waste was correctly segregated, stored, labelled and disposed of regularly.

Assessing and responding to patient risk

Risks to patients were not always assessed appropriately. For example, patients that self-presented to the paediatrics emergency department did not always receive a timely initial assessment or observations. Nursing risk assessments and safety checklists were not always completed.

Processes were in place to stream, triage and assess patients attending the department. However, they were not always effective. Children up to the age of 18 were seen in the PED. Walk in patients underwent an initial review by the streaming nurse. Children were then triaged by a registered children's nurse before being asked to wait to be seen by a doctor. Seriously ill children conveyed to hospital by ambulance were directed to the main emergency department where there was a resuscitation bay designated for children and young people.

Urgent and emergency services

During our inspection, some staff told us they had not undertaken triage training. This impacted on the ability of the service to triage patients within 15 minutes of arrival as it relied on staff who had undertaken the training. This was cited as a risk on the service risk register. Managers told us there had not been any evidence of harm having occurred or incidents reported as a result of delays in triage. Furthermore, some staff told us they were unclear which triage tool they should use. We did not see any evidence of patients not being triaged but considered this could lead to a potential risk to safe streaming and inconsistent practice. Following our inspection, the service provided us with an action plan which stated all relevant staff would undergo a recognised triage training by the end of March 2023.

Patients were not always triaged within 15 minutes of arrival to the PED in line with national standards. For example, we reviewed the PED daily safety checklist for the day prior to our inspection which showed between 7pm and 11pm, there was between a 2 hour and 2-hour 30-minute wait for triage. On the day of our inspection staff told us they were unable to see patients within 15 minutes due to the significant number of attendances. The challenges observed were mainly around patients who were self-presenting. During our inspection we did not see any patients who were conveyed to hospital by ambulance.

Managers told us a review of the PED processes and pathways had been completed. This included a full review of operational processes, quality and safety, audits and data collection, and training and development. The service provided us with the outcome of a baseline audit of 50 records undertaken as part of this review. It showed from 5 to 15 November 2022 overall compliance with time to triage and initial observations standards was 46%.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, observations were not always consistently recorded and completed on time. Staff used the Paediatric Early Warning Score (PEWS) when performing observations to identify the potential risk for deterioration. Information shared with us after our inspection showed as of the end of October 2022, 100% of nursing staff had completed PEWS training. During our inspection we reviewed 10 patient records and found not all patients had their PEWS recorded on an electronic device, and first set of PEWS were not always documented within their PED CAS card. (A CAS card is a terminology used for paper records used within the emergency department to document attendance.) Where patients had scored highly on their PEWS, evidence of review by a more senior clinician in accordance with the escalation procedure was not always documented.

The frequency of observations performed on patients whilst in PED was determined by their condition and previous score. Staff were confident in identifying if a patient's condition had deteriorated and would complete additional observations if deemed appropriate. However, staff told us they could not always complete additional observations due to a high workload within the department and this was one of the main concerns highlighted by staff we spoke with. Staff expressed fear they could miss a deteriorating child.

Following our inspection, we requested PEWS compliance data. Managers told us audits had not been undertaken. However, the service had a plan in place to commence these following our inspection.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. However, staff told us they did not always have time to review this regularly. Staff knew about specific risk issues; however, they were not always dealt with promptly. Most staff had undergone sepsis training. Information provided to us following our inspection showed as of the end of October 2022, 92% of RNs had completed sepsis training. All staff we spoke to were aware of the risk of sepsis. However, staff told us they were not always able to complete sepsis screens within a timely manner due to the volume of patients attending the department. We were aware of an incident where a patient who developed sepsis had not undergone a sepsis screen until more than 7 hours after arrival. This was later completed on the inpatient ward.

Children attending PED following self-harm were required to undergo a multidisciplinary assessment framework, along with a checklist of actions to be taken. During our inspection, we did not see evidence the assessment checklist had been completed. However, some staff we spoke to were aware of the documentation. This was also highlighted as a risk on the department risk register.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough RNs and support staff to keep children and young people safe at the time of our inspection. Shifts were normally covered with 2 RNs and 1 healthcare support worker with an additional twilight shift to enhance staffing. The service did not always meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having two registered children's nurses on each shift. Managers told us they planned the rota in advance to ensure there was at least one registered children's nurse and when the service was particularly challenged, they sought staff from Skylark ward to support. During our inspection, some staff told us they had not completed triage training which meant the service was limited in its ability to move staff to support triage when required. A nursing establishment review was about to be undertaken as it was recognised the current establishment restricted the service to fulfil RCPCH recommendations and provide cover at all times with suitably qualified staff. PED staffing levels was cited as a high-level risk on the service risk register. The risk register stated the nurse staffing establishment did not enable 24/7 minimum cover and staff absence impacted on safe staffing. Staff told us the PED attendances had been very high for some time and they did not consider the staffing levels were always adequate to manage the increase in attendances and acuity of patients attending the department. On the day of our inspection, the service was experiencing unprecedented demand. Staff were struggling to manage the volume of patients attending the department and were unable to take a break.

The number of nurses and healthcare assistants did not always match the planned numbers. Senior staff told us their usual staffing was down by 1 or 2 members of staff. There were gaps in the roster, particularly for the nurses' twilight shifts. Managers reviewed the number and grade of RNs and healthcare assistants needed for each shift in accordance with national guidance. The department manager tried adjusting staffing levels daily according to the needs of patients. Staffing was monitored throughout the day and managers attended meetings 3 times per day in relation to staffing and capacity. If additional support was required in the department, this was escalated during these meetings and where possible, additional resources were supplied.

The department was budgeted for 21.4 whole time equivalent (WTE) nursing and healthcare assistants, leaving a vacancy rate of around 6%. The service had a very low turnover rate.

The service had a high sickness rate. As of November 2022, an overall average for all staff working in PED was at 11%.

Managers limited their use of bank and agency staff and requested staff familiar with the service, staff had a full induction and understood the service. Where gaps in the rota were identified, temporary staffing was used to fill shifts. Managers tried to ensure this was filled with experienced staff who had competencies to work with children. Staff from CYP services were moved to support the department when required. However, the service was limited as not all staff were registered children's nurses.

Recruitment was a rolling process which had previously been managed by the family health division. However, senior staff told us they were hoping to bring this back into the senior nurse's responsibility to enable a better handle on staffing as well as being able to communicate with the PED team better about staffing going forward.

Following our inspection, the service told us they intended to undertake a PED nurse staffing establishment review by the end of March 2023.

Medical staffing

The service had enough medical staff working specific in paediatric emergency department to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not have a paediatric emergency medicine (PEM) consultant as recommended in the RCPCH guidance, Facing the Future: Standards for children in emergency care settings at the time of our inspection. However, managers told us an appointment had been made and was due to start early 2023. Furthermore, there were senior medical staff working within the adult emergency department with paediatric special interests and the service was supported by paediatricians working within the wider CYP services. Systems were in place to ensure there was a paediatrician available in the event of a patient deteriorating.

The department was budgeted for 30 WTE for consultants and senior house officers. The service had low vacancy rates and low turnover rates for medical staff. Sickness rates for medical staff were low, current sickness rate was recorded as 0%.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and were not easily accessible due to the electronic systems and paper format documentation for all staff providing care.

Patient notes were not always comprehensive, and some staff told us they could not always access patient records easily due to the electronic system and paper format process. We reviewed 10 patient records and we found it quite difficult to navigate the system to review patients' records. This was because some notes in use were in paper format and some notes were recorded electronically.

We found all 10 records had some missing information. Some handwritten records and electronic records had minimal information contained within them, despite there appearing to be a plan for the patient to be admitted. Staff told us when doctors reviewed patients and decided a bed was required, electronic referrals were immediately completed. When questioned why there was no evidence of any review being documented to support a referral, staff were unable to explain this.

Urgent and emergency services

Medicines

The service used systems and processes to safely prescribe, record and store medicines. However, there were delays in administering prescribed medication.

Staff followed systems and processes to prescribe and administer medicines. However, at times we found there were some delays prescribing and administering antibiotics. Staff told us the delays in administering medicines were a result of high workload, not enough staff and an increased number of attendances in the department. Furthermore, where intravenous medicines, such as antibiotics were prescribed, this required 2 RNs to check and administer medicines. Staff had to wait for another staff member to become free which added an additional delay in the administration of time critical medicines.

Staff stored and managed all medicines and prescribing documents safely. All areas had ready access to emergency medicines and medicines to treat hypoglycemia. Staff followed national practice to check patients had the correct medicines when they were admitted.

Incidents

The service did not always manage patient safety incidents well. Staff were aware of what constituted an incident and near miss, however, some staff we spoke with told us they did not always have time to report all incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service did not always manage patient safety incidents well. Staff knew what incidents to report and how to report them. They were aware of what constituted an incident and near miss. However, they did not always report incidents. Data we reviewed showed the service raised 48 incidents between November 2021 and October 2022. All 48 of these incidents were classified as no harm (44) and low harm (4). Staff told us there had been areas of concerns and incidents which they identified, but they had not reported them. One example which staff did not always report was low staffing numbers, staff told us this was because they had no time to complete incident forms. Staff told us incidents which had a direct impact on patient care and potential harm were always reported to the nurse in charge if front line staff had no time to complete an incident form.

The service had reported no never events in the last 12 months. If appropriate, managers shared learning with their staff about never events that happened elsewhere. Staff met to discuss the feedback and look at improvements to patient care. During handover, important learning and feedback from incident investigations was discussed amongst other important issues. Staff told us they used the same brief during handover for a week to ensure all staff were made aware.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if or when things went wrong. Staff told us they received feedback from investigation of incidents and met to discuss the feedback and look at improvements to patient care.

Is the service well-led?

Requires Improvement 

Urgent and emergency services

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Leaders had the skills and abilities to run the service. However, the service was undergoing a process of management change at the time of our inspection. The service previously reported into the family health division. It was recognised the service required greater oversight and clinical leadership from urgent care. At the time of our inspection, the service management had been taken over by urgent care. This took effect from 7 November 2022 and at the time of our inspection, leaders were in the process of embedding the service into a new structure. There was a clinical, nursing and operational lead for the urgent care service. Leaders were experienced and understood the challenges facing the Paediatric Emergency Department (PED) as well as the immediate challenges of fully integrating the service into the main emergency department.

The Royal College of Paediatrics and Child Health recommends every emergency department treating children must be staffed with a Paediatric Emergency Medicine (PEM) consultant with dedicated session time allocated to paediatrics. This was not in place at the time of our inspection. However, emergency care leaders had recruited into the post and were expecting the post holder to start early 2023. Processes were in place to ensure support was provided from the paediatric team.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address these. During our inspection we interviewed the triumvirate and local leadership. They were able to tell us about current challenges and how they are addressing them. For example, leaders were aware the increase in attendances meant the location of the department was not always large enough to meet the needs of patients. As a result, the new leadership team had a plan in place to relocate the service within close proximity to the main emergency department with a larger waiting room. This meant there would be more space for staff to maintain a visual of all patients. Furthermore, leaders recognised the need to review the nurse staffing establishment to ensure it reflected the increase in demand, acuity and competency of staff.

Leaders were visible and approachable. Leaders recognised the PED required more visible leadership to provide management oversight and support to staff. An experienced emergency department matron had been seconded to the department for an initial 6-month period to review the systems and processes, develop staff and support them through a transitional period. At the time of our inspection, this was in its infancy and most staff working in the department commented the new leadership team were visible and keen to improve standards of care.

Vision and Strategy

The service did not have a vision for what it wanted to achieve. However, the service had a medium-term strategy to increase the capacity of the department and integrate into the main emergency department.

The PED did not have its own vision and strategy. However, the short to medium term plan was to integrate the PED into the urgent care pathway and relocate the service. The leadership team were committed to improving patient flow and

improving the environment. We were told by senior teams that the trust had plans in place to move the department to a more suitable space by the end of January 2023. The service was in the process of being reviewed and this information was intended to inform the development of a plan to improve the service once it had integrated fully to urgent care. We recognised the changes were very new and the service would need some time to fully embed.

Staff we spoke with could describe the wider vision for the trust; this was displayed throughout the PED.

Some staff told us they were actively encouraged to speak up if they had concerns; however, staff could not tell us who the freedom to speak up guardians were or how to access support if they had concerns.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. However, the staffing levels, acuity and environment impacted staff's ability to deliver high standards of care.

Some but not all staff felt respected, supported and valued. We received variable feedback from staff. Most staff described being under significant pressure, particularly at the time of our inspection where the service was experiencing unprecedented demand. During our inspection, we observed staff were distressed and frustrated as a result of challenges in the department. For example, the increase in demand, feeling there were not enough staff to provide safe care and struggling to manage the increase in attendances in a small department.

Staff were focused on the needs of patients receiving care. However, the staffing levels and acuity impacted their ability to deliver high standards of care. Nursing staff all commented that the service was understaffed and said it impacted on their ability to provide an adequate level of care to patients. Staff felt unable to dedicate sufficient time to each patient. They were fearful that the increase in demand would lead to further deterioration of the department.

Staff generally understood the challenges and considered managers were doing what they could. Staff told us the new matron supported them at times of peak activity.

Not all staff felt positive and proud to work in the organisation. However, all staff were committed to their job, were proud to work in their team and were driven by caring for and treating children and young people.

Governance

Paediatric emergency department governance processes were improving but had not yet fully integrated into the urgent care service. Staff were not always clear about their roles and accountabilities. However, they had regular opportunities to meet, discuss and learn from the performance of the service.

The PED governance processes were improving but had not yet fully integrated into the urgent care service. Staff from the department attended monthly emergency medicine directorate clinical governance meetings. These meetings were chaired by the clinical director for the department which had multidisciplinary team attendance. Key governance issues were discussed, including (but not limited to) incidents, complaints, risks, clinical effectiveness and audits. These meetings covered both the adult and paediatric departments and demonstrated where aspects from both departments had been raised for escalation to the board. This was the main governance meeting where members of the department were required to attend. Staff attended other internal governance meetings including mortality and morbidity meetings. Any learning or actions were escalated and discussed at the department's main governance meeting.

Urgent and emergency services

We reviewed 2 sets of joint acute medicine and emergency department mortality and morbidity meeting minutes, both meeting minutes did not include PED cases. However, these had improved from our previous inspection where the emergency and medicine departments had joint meetings to discuss serious incidents and learning. This was an area for improvement which was in the process of being addressed as the PED integrated into the urgent care department.

Staff were not always clear about their roles and did not always understand what they were accountable for and to whom. At the time of our inspection, the service was going through transition in terms of governance and plans to relocate the service. There had been changes in senior nurses and managers. Some staff were unclear about clinical aspects of their role. For example, not all staff knew what triage tool they should be using. However, there were regular meetings throughout the day to discuss the flow and capacity within the hospital. Staff participated in these meetings and escalated the pressure level within the department. From these meetings, the trust was able to accurately assess the pressures they were currently facing and took appropriate action. On the first day of our inspection, the trust was reporting an Operational Pressure Escalation Level (OPEL) of 4. This meant they were facing a very high level of demand and some non-urgent activity would be cancelled to support areas, such as urgent care.

Following our inspection, the trust implemented an improvement plan which included an action to implement standard operating procedures (SOP) in the department. The SOP was in the process of being written and included guidance to staff to support the appropriate streaming of patients, timely escalation of risk and demand, escalation of operational pressures and delays in triage, assessment and treatment and how to seek support. A matron had been re-located to the department from the main emergency department to support the staff through this period.

Management of risk, issues and performance

Processes to improve quality and performance were not yet embedded into the paediatric emergency department. Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact.

Processes to improve quality and performance were not embedded. For example, following our previous inspection, we identified concerns with the quality of nursing records in the department. A new nursing record had been developed. However, during our recent inspection, we identified continued concerns with the poor quality of nursing records which suggested there had not been enough scrutiny and oversight afforded to this by the local management team. Furthermore, we did not see evidence measures were in place to assess performance against national quality standards in the PED. For example, time to initial assessment, time to medical review, 15-minute observations, pain assessments and timeliness of analgesia. Whilst we saw the service undertook sepsis screening audits and compliance with sepsis 6 actions, we were not assured these were effective in making improvements. Following our inspection, the service identified key quality improvement actions to improve performance. For example, by the end of January 2023, the service intended to establish a weekly audit of key quality indicators, reporting into urgent care governance. We were assured these measures would drive improvements in safety and patient experience.

Leaders were aware of their risks within the department. They could describe actions to mitigate these risks, but the actions had not all yet been implemented. Leaders were new to the PED and had plans in place on how to improve the department. The leaders were at a very early stage of quality improvements within PED and were highly motivated to make the changes. The leaders were aware of the impact the PED environment had on both staff and patients. They were aware of the greater risks if not embedding changes effectively.

Following our inspection, the service provided us with a copy of their risk register. We saw the department had 14 risks in total, 1 of which was rated as significant risk, 9 as high risk and 4 as moderate risk. The highest risk was around delays in referring to the local safeguarding hub. We saw the risks we identified during our inspection were included on the risk register.

We reviewed the trust operational escalation policy. The purpose of the policy was to ensure that at times of increased pressure, patients receive the highest levels of care and experience whilst minimising risk. During our inspection the trust were operating at OPEL 4, which meant they were under extreme pressures with significant delays. We found the PED to be overcrowded and congested with patients queuing in corridors and standing in any space they could find. We saw the trust had implemented paediatric escalation by closing the paediatric assessment unit to increase inpatient beds. This meant more beds had been made available to ease pressure in the PED.

The trust also had an emergency department standard operational procedure (SOP) to ensure the department had a clear operational procedures for responding to a day to day variations in demand and patient flow, ensuring that appropriate processes were in place to support clinical decisions on escalation, which minimises the risk of overcrowding and breach of urgent and emergency care standards. However, this required updating to integrate detail around the PED. The service was in the process of reviewing this at the time of our inspection.

Information Management

The service did not always collect reliable data. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service did not always collect reliable data. Staff told us they were sometimes unable to update patient records due to high workload. For example, staff were not always able to record observations on electronic systems at the time as they did not always have access to equipment or experienced competing priorities. During our inspection we found safeguarding information was recorded on both paper and electronic patient records. We found inconsistent recording of information which did not always correlate. This meant data was not always accurate in providing an overview of service activity and performance to ensure informed and effective decisions could be made to improve the service.

Engagement

Leaders and staff did not always openly engage with patients and staff.

Staff within the department participated in the staff survey in 2021. The trust informed us that the 2021 staff survey only had 6 returns for PED which was below the threshold of 11 for data to be provided. This meant staff views were not consistently collected to improvement the service.

The patient satisfactory survey in June 2022 showed that 92% of respondents were satisfied with PED services, with a reduction of satisfaction in July (77%), August (71%) and September 67%, with a slight increase in October 2022 75%, and 100% in November 2022. However, the information shared with us showed the overall total patients that feedback had reduced from 12 to 4 participants. This meant views of patients and their carer's were not consistently collected to improve the service.

Learning, continuous improvement and innovation

Urgent and emergency services

All staff were committed to improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders supported participation in research.

Since the change of directorate within PED, a thorough review was undertaken to identify current practices and areas for improvement.

Immediate actions undertaken were:

- An adult emergency department matron was moved to the PED full-time to improve safety and quality.
- Senior nurses were moved from the main emergency department to the PED to support staff.
- The trust infection, prevention and control team undertook an inspection of the area for compliance with infection prevention control standards.
- A fire safety inspection of the area was undertaken for compliance with fire regulations.
- A senior nurse in charge from adult emergency department was in place to oversee the department outside of normal working hours.
- Senior leadership planned to conduct a team weekly meeting to develop the quality improvement plan.
- Managers reviewed all open and archived risks, to ensure that all necessary risks were articulated on the risk register and they identified any that required escalation to the divisional/corporate risk register.
- Quality audits were in the process of being implemented.
- Leaders identified a location to move the PED to a larger unit, adjacent to the adult emergency department.

Senior staff told us that a full review of all process and pathways was underway within the PED. An improvement plan was being developed with key areas of focus around:

- Audit and quality measures
- Estate and environment
- Infection prevention and control
- Mental health patients
- Minor injuries and illness
- Pharmacy and stores
- Resuscitation
- Safeguarding
- Staff training and competencies
- Staffing levels

Urgent and emergency services

Data we received stated that the initial improvement plan proposed was extensive and required further detail regarding key performance indicators and metrics. The service intended to fully complete the improvement plan by the end of January 2023 for reporting in February 2023 through directorate and divisional governance. Improvement actions were ongoing, with leadership and oversight provided by the urgent care directorate and medicine division triumvirate, and engagement with the medicine governance team.

Research for the PED was being undertaken. For example, the Febrile Infant Diagnostic Assessment and Outcome Study. Senior teams told us that they were exploring how to develop the workforce and the interchange between main and PED.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Urgent and Emergency Care

- The service must ensure all equipment is cleaned and sanitised between patient use and control measures are in place to document when equipment was last cleaned. Regulation 12 (1)(2)(e)(h): Safe care and treatment.
- The service must ensure effective systems are in place and fully implemented to assess and treat patients at risk of sepsis in a timely manner. This includes but is not limited to ensuring patients undergo a timely assessment to determine their risk of sepsis, and patients at risk receive a medical review, diagnostics and treatment within a timely manner. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The service must ensure patients undergo timely assessments in line with national standards. This includes time to triage, first set of observations, medical assessments and senior reviews. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The service must ensure that risks to patients are appropriately assessed and mitigated. This includes but is not limited to mental health and safety checklists. Regulation 12 (1)(2)(a)(b): Safe care and treatment.
- The service must ensure systems and processes to safeguard patients from abuse and improper treatment are fully implemented. This includes but is not limited to ensuring all staff have completed the appropriate level of safeguarding training; safeguarding checks and assessments are completed; and actions taken to safeguard patients are documented. Regulation 13 (1)(2)(3): Safeguarding service users from abuse and improper treatment.
- The service must ensure the paediatric emergency department is suitable for the purpose it is being used and appropriately located. This includes but is not limited to ensuring there is adequate space and capacity to meet demand; ensuring there is appropriate visual and supervision of patients at all times; and ensuring there is sufficient equipment so that patients are safe. Regulation 15 (1)(2): Premises and equipment.
- The service must ensure accurate, complete and detailed records are maintained for each patient attending the department. This includes but is not limited to ensuring there is a record of the care and treatment provided; decisions taken in relation to the care and treatment provided are documented; safeguarding information is accurately and effectively documented; and all records are accessible to staff. Regulation 17 (2)(c) Good governance.

Urgent and emergency services

- The service must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff working within the paediatric emergency department. Regulation 18 (1): Staffing.
- The service must ensure the paediatric emergency department nursing and medical staffing requirements meet the Royal College of Paediatrics and Child Health. Regulation 18 (1)(2)(a)(b): Staffing.
- The service must ensure all relevant staff are trained to the highest-level of life support. Regulation 18 (1)(2)(c): Staffing.

Action the trust SHOULD take to improve:

Urgent and Emergency Care

- The service should ensure that all staff are aware of who the freedom to speak up guardians are and their roles. Regulation 17 (1)(2)(e): Good governance.

Our inspection team

The team that inspected the service comprised of 2 CQC lead inspectors, a team inspector a children's team inspector and 2 specialist advisors. The inspection team was overseen by Charlotte Rudge, Interim Deputy Director of Operations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance