Kettering General Hospital NHS Foundation Trust

Kettering General Hospital

Inspection report

Rothwell Road
Kettering
NN16 8UZ
Tel: 01536492000
www.kgh.nhs.uk

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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 inspection of Children and Young Person's (CYP) services, using our focused methodology under the CYP and Urgent and Emergency Care (UEC) core service frameworks. We undertook an unannounced site visit on 26 April 2023. We carried out this inspection to check the quality of services in response to a Section 29A Warning Notice (WN) and letter of intent we served to the trust in December 2022.

We served a WN to the trust following our inspection on 6 December 2022, 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. We also served a letter of intent to the trust in relation to staffing levels on Skylark ward following our visit on 19 December 2022.

During our inspection we inspected both the CYP and UEC core services using our focused inspection methodology. During our inspection we used our focused inspection methodology to review specific elements of safe and well led identified within the Section 29A WN issued in December 2022, within CYP and UEC core services. We inspected the safe and well led key lines of enquiry for both core services only. However, we only reviewed specific elements of safe and well led in line with the Section 29A WN.

We visited the Paediatric Emergency Department (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, play therapists, administrative staff, registered nurses, ward managers, matrons, doctors, and service leads. We reviewed 16 patient records and other documentation including incident reports, meeting minutes, quality audits and trust policies and procedures.

We spoke to 2 patients and the parents of 16 patients.

Following a review of all the evidence from this follow-up inspection and a review of additional information provided by the trust before and after our inspection, we are satisfied that improvements have been made and the requirements of the WN have been met. However, we did not re-rate either the UEC or CYP core service at this inspection. The previous ratings of requires improvement for UEC and inadequate for CYP remain. We are monitoring the progress of improvements to services and will re-inspect them as appropriate.

Urgent and emergency services

Inspected but not rated

We did not rate this service at this inspection. The previous rating of requires improvement remains. We found:

- Assurance systems and processes were in place to safeguard children and young people from the risk of harm or neglect had improved. Records demonstrated improvements in nursing and medical staff completing safeguarding checklists. Staff routinely checked nationally approved child protection information sharing systems and trust alert systems when assessing safeguarding risks. Staff understood how to protect children, young people and their families from abuse, and worked well with the inpatient ward and other agencies in doing so. The use of facilities and premises had improved to keep patients safe. Timeliness of patient observations had improved; we saw signs that changes were beginning to be embedded in practice. Processes for escalating unwell patients and those showing signs of deterioration had improved. Compliance with sepsis screening standards had improved. Processes in place to stream, monitor and escalate patients at risk of sepsis had improved.
- The Children and Young Person's quality improvement programme was effective in driving improvements within the paediatric emergency department. Processes to improve quality and performance were embedded.

Is the service safe?

Inspected but not rated

We did not rate this key line of enquiry at this inspection. The previous rating of inadequate remains.

Safeguarding

Assurance systems and processes to safeguard children and young people from the risk of harm or neglect had improved. Records demonstrated improvements in nursing and medical staff completing safeguarding checklists. Staff routinely checked nationally approved child protection information sharing systems and trust alert systems when assessing safeguarding risks. Staff understood how to protect children, young people and their families from abuse, and worked well with the inpatient ward and other agencies in doing so.

During our previous inspection in December 2022, we found the assurance processes in place did not always demonstrate that children and young people were safeguarded from the risk of harm or neglect. During this inspection, we found improvements had been made.

Staff understood their roles and responsibilities in safeguarding patients from the risk of harm or neglect. During our previous inspection we found that while staff had access to training on how to recognise and report abuse, not all staff had completed it. We previously found only 76% of nursing staff had completed level 2 safeguarding children training and 66% level 3. Medical staff safeguarding training data was not available. During this inspection, we found improvements had been made. All Registered Nurses (RN) working in the Paediatric Emergency Department (PED) had completed level 2 safeguarding children training and 95% had completed level 3. Furthermore 88% of medical staff had completed safeguarding level 2, however, only 52% had completed level 3. This compliance data included all Urgent and Emergency Care (UEC) medical staff and not just those for paediatrics. Following our inspection, managers told us a plan was in place for all staff to have completed this training by the end of August 2023.

Urgent and emergency services

Both medical and nursing staff we spoke to during our inspection had a comprehensive understanding of their role to carry out safeguarding checks, assessing safeguarding needs and taking appropriate action. Both medical and nursing staff we spoke to described recent safeguarding concerns they had identified and how they had acted to safeguard a child. Staff understood where to record this information.

During our previous inspection in December 2022, we found staff did not always follow safe procedures for children visiting the PED. While there were systems and processes to assess a child's social history and check nationally approved child protection information sharing protocols, staff did not always use these systems effectively. Staff did not always complete the electronic system checks to determine whether there were known safeguarding concerns. Alerts were not always added to electronic patient records to alert staff to potential safeguarding concerns, such as frequent attenders. Staff did not always complete social background assessments and the voice of the child was not recorded.

Following this inspection, the service implemented a quality improvement plan to improve safeguarding systems and processes. The safeguarding checklist was improved to make it easier for medical and nursing staff to complete. It included all necessary information to assess whether a child was or could be at risk. The checklist was in the front of the patient's accident and emergency assessment (CAS) card for ease of access. Managers introduced a process to second check these forms to ensure all safeguarding checks had been completed, action had been taken where required and followed up. The trust wide safeguarding children's lead attended the PED daily to support staff with any safeguarding matters. They introduced a daily handover of any safeguarding concerns identified by nursing staff. This meant they had oversight and could ensure patients were safeguarded.

Managers implemented a minimum standard safeguarding audit to improve practice and ensure appropriate checks had been completed. Weekly audits undertaken from January to April 2023 showed an average compliance was 92% against a target of 90%. Managers also used audit to check for completion of the safeguarding checklist. Compliance with this audit was variable but improving. For example, 50% of safeguarding checklists had been fully completed in March 2023, which had increased to 85% by the end of April 2023. The audits enabled managers to quicky identify non-compliance and address this with staff.

We reviewed 7 records during our inspection, and they all demonstrated staff had completed appropriate checks. All records had a fully completed safeguarding checklist which had been jointly completed by nursing and medical staff. Staff checked nationally recognised child protection information sharing systems and electronic medical records to identify any known safeguarding concerns and alerts. We found detailed information recorded on the patient electronic record by medical staff as well as the voice of the child where possible. We saw evidence of staff using professional curiosity to assess whether there were any safeguarding concerns. For example, where a child had sustained an injury or was a frequent attender. We saw evidence of safeguarding referrals being made when required and sharing of information to safeguard children. For example, with relevant professionals including the inpatient ward staff prior to transfer.

During our previous inspection staff told us they did not have time to complete safeguarding documentation. We saw improvements had been made to staffing levels since our previous inspection. This meant that staff had more time to complete safeguarding documentation effectively. We also saw improved teamwork between medical and nursing staff in assessing and responding to any safeguarding concerns.

Following our inspection, we were assured the requirements of the Section 29A Warning Notice (WN) in relation to safeguarding had been met. Whilst improvements had been made, managers recognised continued improvements were required to further improve audit compliance and maintain the changes made overtime.

Urgent and emergency services

Environment and equipment

The use of facilities and premises had improved to keep patients safe. The Paediatric Emergency Department (PED) had moved to a more suitable location within close proximity to the main Emergency Department (ED).

During our previous inspection in December 2022, we found the space and capacity of the PED was not sufficient to manage the volume of attendances, particularly at times of increased demand. We observed corridors and walkways were obstructed with children and their parents/carers waiting to be seen. Following our inspection, the service relocated the PED to an alternative location next to the main ED. The area had a larger footprint and larger waiting area to accommodate an increase in attendances. There were 2 triage rooms located in the waiting room and 8 treatment cubicles. A high dependency cubicle and 3 majors cubicles were in direct line of site of the nurses station. These were used to treat and monitor the sickest patients.

During our previous inspection we found the layout of the department meant staff did not always have sight of patients in the department. 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. During this inspection we found improvements had been made. We observed staff had good oversight of the department and a visual of all patients. Closed circuit television (CCTV) of the waiting area was observable by screen at the nurse in charge station. A second Health Care Assistant (HCA) was added to the planned staffing levels, this staff member was located in the waiting area. However, staff told us the second HCA shift was not always filled. The triage rooms were located within the waiting room. This meant the waiting room was observable by staff when not with a patient. Treatment cubicles were in front of the nurses station, with high visibility cubicles available for the sickest patients requiring continuous monitoring.

We previously found in the event of an emergency the overcrowding of the department had the potential to block access and impact staff ability to effectively care for and treat the deteriorating patient. During this inspection we observed the waiting room was adequately large to manage capacity on the day we inspected. Managers had processes in place to escalate when capacity reached more than 25 patients in the department. Emergency trolleys were accessible to all areas and corridors were clear and free from hazards.

During our previous inspection, we found 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. During this inspection, we found improvements had been made. Managers had implemented a Standard Operating Procedure (SOP) explaining how staff were to guide patients through the department or home based on the triage outcome. The increase in treatment cubicles meant that the sickest patients were streamed to majors and those requiring treatment to consultation cubicles. Patients with minor illness or injury were streamed to the co-located Minor Illness and Minor Injury (MIaMI) department and those who were fit to sit were streamed for further monitoring and review in the waiting area. The service was close to the resuscitation area should a rapid transfer be required. We observed the nurse and consultant in charge had good oversight of the department and worked well together to ensure all patients were streamed to the right place at the right time.

During our previous inspection we found the department had a limited number of bed spaces available with piped gases, such as oxygen, medical air, and suction. During this inspection we found significant improvements had been made. Each cubicle had piped oxygen and suction and there was an adequate supply of medical air when required.

During our previous inspection we found 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. During this inspection we found improvements had been made. The PED had been relocated to sit alongside the main emergency department therefore they had direct access to blood gas machines. Furthermore, we saw evidence in patient records the blood gas machine was linked to the patient record. Patient identifiers were included on blood gas result receipts.

Assessing and responding to patient risk

Timeliness of patient observations had improved, showing signs changes were beginning to embed in practice. Processes for escalating unwell patients and those showing signs of deterioration had improved. Compliance with sepsis screening standards had improved. Processes in place to stream, monitor and escalate patients at risk of sepsis had improved.

During our previous inspection in December 2022, we found systems and processes to assess, monitor, and mitigate risks to patients receiving care and treatment were not operating effectively. During this inspection we found managers had taken immediate action and improvements had been made.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Timeliness of patient observations on arrival and throughout admission had improved. During our previous inspection we found the first set of patient observations were not always undertaken within 15 minutes of arrival to the department. Paediatric Early Warning Score (PEWS) were completed but not always on time. Where patients had scored high on their PEWS, evidence of review by a more senior clinician in accordance with the escalation procedure was not always documented. Staff told us they did not have capacity due to workload to complete all observations on time.

Following our inspection, managers took immediate action to improve timeliness of observations and escalation. PED national standards were implemented, and weekly audits undertaken to assess compliance. Staffing levels were increased to support busier times of the day. The service took action to review and increase staffing levels within the department prior to undertaking a full staffing review to ensure the service was safe. The planned RN and HCAs had increased. Staff had been seconded from the main ED to increase the number of RNs working in the PED. An agreement for use of temporary staffing had been made. Managers introduced a second HCA for each shift to undertake the first set of observations during triage. The CAS card was revised to include an escalation section to support timely escalation and review of deteriorating patients.

Audits undertaken from 19 January 2023 to the end of April 2023, showed week on week improvements in compliance with the first set of observations being completed within 15 minutes. For example, on 19 January, 30% of observations were completed within 15 minutes against a 90% target. Compliance levels in the 3 weeks prior to our inspection, consistently exceeded the 90% target. The service reviewed all cases where the 15-minute target was not achieved and, in these cases, they were mostly only a few minutes late. Furthermore, audits demonstrated week on week improvements with PEWS compliance. The service exceeded the 90% compliance target in the 3 weeks prior to our inspection.

During our inspection, we reviewed 7 patient records and found 100% of observations were completed within 15 minutes of arrival, times ranging from 2 minutes to 14 minutes. Furthermore, we found PEWS were undertaken within timescales set in all records we reviewed.

Urgent and emergency services

Staff we spoke to during our inspection told us the staffing levels and the streaming processes in the department had improved. This meant they were more able to complete observations in a timely manner and ensure the sickest patients underwent continuous monitoring.

A nationally recognised triage tool was consistently implemented. Patients were appropriately streamed and reviewed by a doctor based on level of urgency. Processes for escalating unwell patients and those showing signs of deterioration had improved. During our previous inspection we found patients were not always triaged within 15 minutes of arrival to the PED in line with national standards. There were not always enough staff to ensure patients were triaged in a timely manner. Following this inspection, the service took immediate action to improve. The service revised and implemented a SOP for the PED which provided clear guidance to staff to support effective triage, streaming and escalation of the deteriorating patient. A review of the staffing model was undertaken to ensure all areas of the department including triage were appropriately staffed.

During our previous inspection, not all staff had completed the Manchester Triage Score (MTS) training and not all staff could describe what triage tool they used. Data provided to us by the trust during this inspection showed 100% of relevant RNs had completed MTS training to enable them to triage patients effectively. The training included education on other emergency services offered such as streaming to MIaMI. All staff we spoke to could describe the triage process and considered the new SOP as improving safety, flow, and the patient experience.

Audits undertaken from 19 January to end of April 2023, showed week on week improvements in compliance with 15-minute triage national standards. For example, on 19 January, 39% of triages were completed within 15 minutes against a 90% target. Compliance levels in the 8 weeks prior to our inspection consistently exceeded the 90% target. Managers reviewed all cases where the 15-minute target was not achieved and, in these cases, they were mostly only a few minutes late. During our inspection we reviewed 7 patient records and found they were all triaged within 15 minutes of arrival.

During our inspection we observed staff completing escalation tables in the patient CAS card to document when a patient was escalated and why. This prompted staff to act on deteriorating patients in a timely manner, record it and enabled managers to have improved oversight of performance.

Data from January to April 2023, showed the average time to senior review was 56 minutes. This meant patients were being assessed by a senior doctor in line with the national standard of 60 minutes.

In the 7 patient records we reviewed, we found, where there was an increase in the PEWS, patients were escalated by nursing staff and reviewed by an appropriate grade doctor quickly. All patients underwent a senior review within 60 minutes. We also found patients were appropriately triaged to the correct location based on their triage score, PEWS and clinical condition.

Compliance with sepsis screening standards had improved. Processes in place to stream, monitor and escalate patients at risk of sepsis had improved. During our previous inspection we found sepsis screens were not always completed in a timely manner. The service took immediate action to improve. There was an emphasis on improving staff knowledge and confidence. For example, we saw a sepsis education board in the department to promote best practice. The service had introduced a sepsis link nurse role who worked closely with the trust wide sepsis team to deliver sepsis refresher sessions in the department. The service had a sepsis escalation board in place which was a visual prompt to record patients' high risk of sepsis and maintain oversight of actions taken to review, monitor and treat patients. Safety huddles were undertaken 3 times a day where cases of clinical concern, urgent priority and those requiring escalation were discussed with the nurse in charge, consultant in charge and administrative staff; this included patients at risk of sepsis.

Urgent and emergency services

The PED was relocated at the end of January 2023. This included a high dependency cubicle and 3 majors bays where patients high risk of sepsis were streamed to. The cubicles were right in front of the nurse/doctor station, highly visible and ensured continuous monitoring was in place. During our inspection, we saw a patient high risk of sepsis immediately placed in the high dependency cubicle on arrival with continuous monitoring in place.

Following our previous inspection, the service provided weekly progress reports which showed improvements had been made overtime with compliance against sepsis screening standards. From January to April 2023, audits demonstrated an average 89% compliance against a 90% target. Compliance over this time had gradually improved with the 90% target being exceeded in the 6 weeks prior to our inspection. During our inspection we reviewed 7 patient records and found all had a fully and accurately completed sepsis screen. One patient assessed as high risk of sepsis was immediately reviewed on arrival by a consultant. The sepsis 6 actions were de-escalated, with continuous monitoring and regular senior doctor reviews undertaken. Where there were signs of deterioration, further sepsis screens were completed and escalated.

Following our inspection, we were assured the requirements of the Section 29A WN in relation to patient observations and escalation processes, PEWS compliance and sepsis screening had been met. Improvements in compliance was demonstrated through audits and our inspection, and improvements were showing early signs of sustained performance.

Is the service well-led?

Inspected but not rated

We did not rate this key question at this inspection. The previous rating of requires improvement remains.

Management of risk, issues and performance

The Children and Young Person's quality improvement programme was effective in driving improvements within the paediatric emergency department. Processes to improve quality and performance were embedded into the department.

The Children and Young Person's (CYP) quality improvement programme implemented following our inspection in December 2022 was effective. Managers implemented an immediate action plan in response to the Section 29A WN issued requiring significant improvement. The service undertook a series of listening events with staff and feedback was used to inform quality improvements. There were 2 workstreams in relation to the PED to improve the quality and safety of the service. This included all areas of concern cited in our Section 29A WN linked to the PED as well as wider quality improvements. Weekly progress reports demonstrated improvements had been made following our inspection.

Processes to improve quality and performance were embedded into the paediatric emergency department. During our previous inspection we found measures to improve quality and performance were not effective and the service did not have oversight of performance against national standards. Following our inspection, the trust took immediate action to improve.

The service implemented a Standard Operating Procedure (SOP) for the department once it had been relocated. The SOP included guidance to staff about the patient journey, roles and responsibilities, escalation processes, national standards, audit requirements and governance arrangements. National operational standards were implemented as

well as targets to improve quality in timeliness of observations, sepsis and safeguarding. A programme of weekly audits was undertaken to measure progress against the Section 29A WN and PED national standards. This also enabled managers to identify good practice and areas for improvement. Staff from the main emergency department were seconded to the PED to support safe staffing as well as driving quality improvements. A matron was seconded to oversee quality improvements alongside the Head of Nursing.

Weekly progress reports sent to us following our previous inspection demonstrated the PED had made gradual improvements across all areas. Notable improvements were made with achieving national compliance standards with triage within 15 minutes, first set of observations within 15 minutes and senior medical reviews within 60 minutes. Safeguarding was identified as an area for improvement. Audits undertaken resulted in the service revising its process to a more streamlined assessment process. Audits showed, once changes had been implemented, performance in meeting safeguarding standards had improved. Furthermore, sepsis screening was identified as an area for improvement. Targeted work was undertaken with staff. For example, training and workshops, a sepsis link nurse was identified and learning from audits was shared with staff through safety huddles and departmental meetings. Audits undertaken from January to April 2023 showed performance gradually improving over this time.

During our inspection, we reviewed 7 patient records, and noted improvement in the completion of patient assessments, triage, observations, sepsis screens and safeguarding assessments and checks. We were assured the quality improvements implemented and audits were positively impacting performance. We were therefore assured improvements had been made and the requirements of the Section 29A WN had been met.

Services for children and young people

Inspected but not rated

We did not rate this service at this inspection. The previous rating of inadequate remains. We found:

- Systems and processes to check nationally approved child protection information sharing systems and assess a patient's social history were effectively implemented. Managers and staff in charge had oversight of patients where there were safeguarding concerns. Actions taken in response to safeguarding concerns were fully documented. Systems and processes were in place to ensure medical air sockets were capped off when not in use. Point of care blood gas test receipts corresponded with the patient number. Improvements had been made in the timeliness of patient observations. Neurological observations were completed in line with trust policy. Staff identified and quickly acted upon children and young people at risk of deterioration. Staff completed and updated risk assessments for each child and young person. Staff assessed a patient's risk of dehydration on admission and improvements were found in the monitoring of a patient's fluid input and output. Improvements had been made in the timeliness of sepsis screens being completed and treatment being administered. There were effective mitigations in place to maintain safe staffing levels on Skylark ward to manage the high vacancy rate for registered nurses. Managers reduced the number of beds available to maintain safe staffing levels. Managers regularly reviewed and adjusted staffing levels and skill mix to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Staff followed systems and processes to prescribe and administer oxygen safely. Daily and weekly checks of emergency equipment and medicines were effective. Managers shared lessons learned with the whole team and the wider service. Processes were in place to improve practice following incidents and monitor the implementation of learning overtime.
- The Children and Young Person's quality improvement programme was effective in driving improvements. A programme of quality and safety audits was in place. Leaders used systems to manage performance effectively.

However:

- Patient temperatures were not always consistently recorded for each patient, though we found compliance had improved since our previous inspection. Documentation was not always fully completed to document the actions staff had taken to assess and treat patients at risk of sepsis. There continued to be a high vacancy rate for registered nurses.

Is the service safe?

Inspected but not rated

We did not rate this key question at this inspection. The previous rating of inadequate remains.

Safeguarding

Systems and processes to check nationally approved child protection information sharing systems and assess a patient's social history were effectively implemented. Managers and staff in charge had oversight of patients where there were safeguarding concerns. Actions taken in response to safeguarding concerns were fully documented.

Services for children and young people

Staff completed safeguarding checks and assessments for patients on admission. Actions taken to safeguard patients from the risk of abuse or neglect were documented. During our previous inspection in December 2022, we found actions taken in response to safeguarding concerns identified on Skylark ward were not always documented in records we reviewed. We found 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.

Following our inspection, the service took immediate action to improve. A review of safeguarding documentation was undertaken. As a result, the service implemented a standalone multidisciplinary safeguarding assessment. This supported staff to document any concerns, actions taken, referrals made, and actions required, to safeguard the patient and their family. The trust wide safeguarding children lead attended the ward daily where any safeguarding concerns were escalated.

During our inspection we found improvements had been made. Both medical and nursing staff we spoke to had a comprehensive understanding of their role in undertaking safeguarding checks, assessing safeguarding needs and taking appropriate action. They described recent safeguarding concerns they had identified and how they had acted to safeguard a child. Staff understood where to record this information.

Nursing records had a clearly labelled safeguarding section where relevant information such as a safeguarding assessment, referrals and child protection records were kept. We reviewed 9 patient records and we found all documented appropriate safeguarding checks had been undertaken. Two records contained a fully completed safeguarding assessment which documented detail of concerns identified. Both assessments included the voice of the child and demonstrated evidence of professional curiosity. We saw both medical and nursing staff documented actions they had taken and plans to mitigate any risks.

Managers and staff in charge had oversight of patients where there were safeguarding concerns. We found improved oversight and handover of safeguarding concerns. For example, electronic handover records documented where there was a safeguarding concern, the risks and actions taken. Furthermore, we saw continuity of care in ensuring the safety of a patient where there were safeguarding concerns identified in the Paediatric Emergency Department (PED) when transferring to the ward. Safeguarding concerns were handed over and it was clear what actions had been taken and what Skylark ward were required to do. During our inspection we attended a multi-disciplinary team handover. We observed each patient was discussed which included an overview of any social and safeguarding concerns. We observed medical and nursing staff expressing professional curiosity during the handover about patients admitted with injuries.

Following our inspection, we were assured the requirements of the Section 29A Warning Notice (WN) in relation to safeguarding had been met. Whilst improvements had been made, managers recognised continued improvements were required to further improve audit compliance and maintain the changes made overtime.

Environment and equipment

Systems and processes were in place to ensure medical air sockets were capped off when not in use. Point of care blood gas test receipts corresponded with the patient number.

Medical air sockets were capped off when not in use. During our previous inspection in December 2022, we found the maintenance of facilities and equipment did not always keep people safe. We observed medical air sockets had not all been capped off when not in use. 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.

Following our inspection, the service implemented a programme of daily checks and weekly audits. Healthcare assistants undertook daily checks and spot checks were completed by the nurse in charge. Weekly audits provided to us from January to April 2023 demonstrated 100% compliance with audit standards over this time. During our inspection, we observed all medical air sockets were safely capped off when not in use across all areas including Skylark ward, the Paediatric Assessment Unit (PAU), and the neonatal unit.

Point of Care Testing (PoCT) machines were linked to the electronic patient record and results corresponded to the correct patient hospital number. During our previous inspection we found PoCT blood gas machines on Skylark ward were not electronically linked to the patient record. We also found the receipts did not always include the patient hospital number as a unique identifier. This meant that there was a risk the results could be accidentally placed in the wrong patient record.

Following our inspection, the service took immediate action. The PoCT machines had been connected to the electronic patient record and access was limited to staff who had undergone appropriate training; 100% of required staff had completed the training. Weekly audits completed from January to April 2023 showed 100% of PoCT receipts corresponded to the correct patient record in 13 out of 16 weeks prior to our inspection, averaging 99% compliance. During our follow up inspection, all 4 records where blood gases had been taken corresponded to the patient record.

Following our inspection, we were assured the requirements of the Section 29A WN in relation to medical air sockets and PoCT testing had been met. In both areas, weekly audits and what we found on our inspection demonstrate these changes are fully embedded in practice.

Assessing and responding to patient risk

Improvements had been made in the timeliness of patient observations. Patient temperatures were not always consistently recorded for each patient, however, we found compliance had improved since our previous inspection. Neurological observations were completed in line with trust policy. Staff identified and quickly acted upon children and young people at risk of deterioration. Staff completed and updated risk assessments for each child and young person. Staff assessed a patient's risk of dehydration on admission and improvements were found in the monitoring of a patient's fluid input and output. Improvements had been made in the timeliness of sepsis screens being completed and treatment being administered. However, documentation was not always fully completed to document the actions staff had taken to assess and treat patients at risk of sepsis.

Timeliness of observations and Paediatric Early Warning Score (PEWS) had improved, showing signs improvements were beginning to embed in practice. During our previous inspection we found PEWS were completed however, 12 of the 14 records we reviewed were not completed in a timely manner.

Following our inspection, the service took immediate action to improve. The service reviewed and revised the PEWS policy and incorporated neurological observations into this. A weekly audit was introduced to review timeliness of observations, escalation compliance and to ensure patients underwent the right observations.

PEWS audits undertaken from January to April 2023, showed staff completed an average of 88% of observations on time. Compliance had gradually improved over this time from 71% in January 2023 to 90% or above from March 2023, exceeding the trust compliance target.

During our inspection, we reviewed 9 patient records and found there were some delays in observations being undertaken and completed on time in 4 records. However, we saw the frequency of delays were less in comparison to our previous inspection. For example, we found:

- Record 1 had 1 delay of 4 hours. No harm was identified, and the PEWS was stable before and thereafter.
- Record 2 had 1 delay of 1 hour. No harm was identified, and the PEWS was stable before and thereafter.
- Record 3 had 2 delays. One delay was 30 minutes and the other 1 hour and 30 minutes. No harm was identified, and the PEWS was stable before and thereafter.
- Record 4 had 4 delays which were mostly overnight, and the delays ranged from 50 minutes to a 4-hour delay. In this case, the PEWS was above 5 and was on hourly observations which were not completed at the set frequency. However, we did see evidence of sepsis screens being completed and a consultant review within 7 minutes of a PEWS of 5 being identified; the patient underwent appropriate treatment over this time.

During our inspection we spoke to 8 parents. Parents were generally happy with the frequency staff visited their child to undertake routine checks. One parent said 'the care provided was amazing. Regular checks were completed since coming out of theatre'.

Feedback from all staff including medical and nursing staff was positive about the improvements made following our previous inspection. Staff felt more confident in escalating their concerns about patients who were showing signs of deterioration and in escalating concerns raised by parents in relation to changes with their child. All staff told us they were working on improving communication with parents to ensure they were listening and acting on feedback and concerns.

Recording of patient temperatures had improved since our previous inspection, however, they were not consistently taken when completing routine observations of vital signs for every patient. During our previous inspection, patients' temperatures were not consistently recorded when undertaking patient observations. We found omissions in completing temperatures in 7 records. The frequency of missed temperatures varied from 1 to 30 occasions in these records.

Following our inspection, the service purchased additional thermometers to support staff to undertake regular temperatures. During this inspection, whilst there were still some omissions in temperatures being completed, this had improved since our previous inspection. We found temperatures were consistently recorded in 5 out of 9 records we reviewed. However, in 1 record there were 3 out of 11 missing temperatures on the PEWS chart and in another there were 8 out of 16 missing. In 2 records we found there was 1 occasion where a temperature was omitted in each record. There was no reason provided as to why temperatures had been omitted.

Neurological observations were completed when required and at set frequencies in line with trust policy. During our previous inspection, we found neurological observations were not always consistently completed where required. During this inspection we found improvements had been made. We found 2 patients required neurological observations and we saw evidence they were consistently completed in line with trust policy.

Staff knew about and dealt with risk issues in relation to sepsis and management of deteriorating patients. During our previous inspection we found staff did not always use their professional judgment to consider factors that may increase the risk of sepsis when undertaking assessments. Following our inspection all staff were required to complete sepsis training. At the time of our inspection 98% of staff had completed it, exceeding the 85% target. Sepsis screens we reviewed demonstrated an improved awareness of red flags in assessing risk of sepsis, as well as PEWS. All staff we spoke to could confidently describe how they undertook a sepsis screen, how they used their professional judgements and what they would do to escalate any concerns.

Services for children and young people

Following our inspection, a simulation suite was created on Skylark ward to support staff, including medical and nursing staff to develop skills and confidence to manage specific situations. For example, this included management of the critically unwell child, sepsis, diabetes management, continuous positive airway pressure and tracheostomy care. These sessions were multi-disciplinary to develop team working in dealing with specific conditions. There was a plan moving forward to repeat these sessions and add on other learning topics relevant to the ward. Similar sessions were undertaken in the neonatal unit. For example, neonatal resuscitation simulation which involved neonatal staff as well as urgent care staff.

Improvements were found in sepsis screening and treatment for patients at risk of sepsis. However, documentation was not always fully completed to document actions staff had taken to treat a patient. During our previous inspection we found patients were being exposed to ongoing risk of harm as sepsis screening and treatment pathways were not always completed in line with trust policy. We found examples where staff had not fully completed the sepsis 6 screen. We also found examples where staff had not completed the sepsis 6 bundle and there was no rationale for not completing them. We found examples where staff had assessed the risk of sepsis as low, despite there being risk factors present with no rationale as why sepsis was not considered.

The service took immediate action to improve. The paediatric sepsis guidelines were shared with all staff through clinical team meetings, safety huddles, ward meetings, handovers, and emails. Sepsis training was provided to staff and the service implemented weekly sepsis audits. The service was supported by the trust wide sepsis team to improve practice and knowledge.

Weekly progress reports provided to us following our previous inspection showed sepsis screening and treatment standard compliance had improved. From January to April 2023, audits demonstrated variable performance with an average 87% compliance against a 90% target. The 90% target had been achieved in 4 of the 16 weeks prior to our inspection and dipped below 80% in 2 out of 16 weeks.

During our inspection we reviewed 9 patient records and found whilst improvements had been made, there were still 2 occasions where sepsis documentation was not correctly completed. Seven out of 9 records had a fully and correctly completed a sepsis screen on admission to the ward in a timely manner. We found evidence where a PEWS had increased or the clinical condition had deteriorated, staff undertook further sepsis screens to re-assess the risk. However, in 1 record we found the risk level had not been selected where there were red flags for sepsis and in another there were 2 sepsis screens in the patient record with the same date and time but a different outcome.

In 1 record where there were red flags for sepsis and the risk level had not been selected, we did not see evidence the sepsis 6 documentation had been completed to indicate staff had initiated appropriate diagnostics and treatment. However, review of the patient records assured us the patient had undergone timely senior medical review and diagnostics. The patient was started on intravenous antibiotics in a timely manner; however, this was not documented on the sepsis 6 bundle.

Processes were in place to monitor management of the unwell child. Daily ward rounds were undertaken where all patients at risk of sepsis were discussed to ensure they were undergoing appropriate treatment and monitoring. Where sepsis audits showed areas of non-compliance, these cases were reviewed, and learning was identified and shared with all staff through safety huddles and weekly clinical meetings (grand rounds).

Shift changes, handovers and ward rounds included all necessary key information to keep children and young people safe. During our inspection we observed a ward round and found there was good oversight of patients who were showing signs of deterioration and were at risk of sepsis. There was multidisciplinary discussion of the patient and a

joined-up plan to manage the patient. Weekly grand rounds were in place every Friday where incoming medical teams for the following week were provided with a detailed handover of all patients by the outgoing medical team on call that week. This was attended by nursing and pharmacy staff also to ensure continuity of care and safe management of patient at risk of deterioration and sepsis. Daily safety huddles were in place. Following our previous inspection, managers introduced a standardised safety huddle format to ensure all relevant risk issues were identified and discussed. This was audited weekly and at the time of our inspection showed 100% compliance with the quality of the safety huddles against set standards.

Staff completed pressure care risk assessments for each child and young person on admission, using a recognised tool, and reviewed this regularly. Improvements were found in the completion of body maps to document any pressure damage. During our previous inspection we found managers 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.

Following our inspection, the service took action to improve practice. Managers implemented basic standards and undertook weekly audits of patient records. Audits undertaken from January to April 2023 showed an average 94% compliance against a 90% target with pressure care risk assessments and body maps being completed within 6 hours of admission. Over this reporting period compliance had gradually increased from 71% in January to being consistently over 95% in the 7 weeks prior to our inspection.

During our inspection, we reviewed 9 patient records and found 8 records had a nationally recognised pressure care risk assessment completed within 6 hours of admission to the ward where required, they were regularly reviewed by staff. In the 1 record where we did not see a pressure care risk assessment, a rationale was provided, and this was later completed. We found evidence of body maps generally being completed. Four records we reviewed had a body map to illustrate a mark or fracture to the body. However, we did not see a body map completed for 1 patient who had sustained a fracture.

Staff implemented preventive actions to reduce the risk of a patient developing skin damage or a pressure ulcer. Managers checked compliance with these preventative actions through weekly audits. The audits demonstrated the service consistently achieved the 90% compliance target and averaged 96% compliance from January to April 2023. During our inspection, we reviewed 2 records where risk was identified, and we saw that actions had been taken to prevent pressure area damage. For example, putting in place cushioning on an oxygen mask. However, we found documentation did not always support staff to record preventative actions taken to reduce the risk of a pressure ulcer or tissue damage to patients assessed as being at risk; we did not see actions taken were always clearly recorded.

Staff assessed a patient's risk of dehydration on admission and improvements were found in the monitoring of a patient's fluid input and output. During our previous inspection we found there was variable compliance with the 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. Inputs and outputs were not always documented 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.

Services for children and young people

Following our inspection, the service took immediate action by setting expectations for staff and implementing weekly monitoring audits. Audits undertaken from January to April 2023 demonstrated on average 88% of fluid balance charts were completed correctly against a 90% target. Over this time the service demonstrated gradual improvements in compliance. For example, from January to the beginning of March 2023, performance was variable and mostly below the compliance level, however, was consistently above 90% in the 7 weeks prior to our inspection.

During our inspection we reviewed 9 patient records, 8 of which were undergoing fluid balance monitoring. All patients underwent a hydration assessment within 6 hours of admission. Six records demonstrated fluid balance monitoring was mostly consistently completed. However, in 2 records we found monitoring was not always completed. For example, there were gaps in the recording, and inputs and outputs were not always totalled.

Following our inspection, we were assured the requirements of the Section 29A WN in relation to PEWS, neurological observations, temperature recording, sepsis, pressure care risk assessments/management and fluid balance monitoring had been met. In some areas such as neurological observations and pressure care risk assessments, audits and what we found on inspection indicated changes were beginning to embed in practice. In other areas changes had been made but further improvements were required. Managers recognised continued focus was required to ensure these changes continued to improve and were embedded in practice overtime.

Nurse staffing

There continued to be a high but reducing vacancy rate for registered nursing staff on Skylark ward, however, there were effective mitigations in place to maintain safe staffing levels. Managers reduced the number of beds available to maintain safe staffing levels. Managers regularly reviewed and adjusted staffing levels and skill mix to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

During our previous inspection in December 2022, we had concerns that the staffing levels were not safe. Both parents and staff also expressed concerns about the staffing levels. They felt that the staffing levels did not allow them to safely care for increasing numbers of patients with complex health needs requiring high dependency care. Actual staffing levels did not always meet planned levels and there were not always effective mitigations in place. Managers told us at the time of our inspection that the staffing levels meant they could not meet the recommended level of nurses in accordance with the Royal College of Nursing (RCN) safer staffing guidance. The service had high vacancy rates across children and young people services. Staff told us where shifts were unfilled, they were often filled with adult trained RNs from other areas who were not skilled or experienced in caring for paediatrics. Managers did not make sure all bank and agency staff had a full induction and understood the service.

Immediately following our inspection on 19 December 2022, the service provided us with a detailed plan outlining how they intended to improve staffing levels to keep patients safe. During our inspection, we found improvements had been made.

The service had a high but reducing vacancy rate for registered nurses. At the time of our previous inspection, Skylark ward had an 18% vacancy rate for registered nurses. Data showed this remained high but had reduced to 15%. The service had taken action to ensure there were enough nursing and support staff to keep children and young people safe. Whilst the service still carried a high vacancy rate for RN, we observed that they had effective mitigations in place to ensure staffing levels were safe. The service reduced the bed capacity from 26 to 22 beds to enable them to maintain

safe staffing levels. The planned staffing levels remained at 7 RNs which included a supernumerary nurse in charge. Based on the reduced bed numbers this meant the service was able to meet the minimum ratio of 1 nurse to 4 patients. RNs on duty had less patients to care for which meant they had more capacity to meet their individual needs and undertake time critical tasks such as complete observations, sepsis screens and administration of medicines.

Managers adjusted staffing levels daily according to the needs of children and young people. Reduced bed numbers and consistent use of temporary staffing meant managers could be more flexible in ensuring patients had the level of care required in line with safer staffing guidance. For example, where there was a patient with high dependency needs, adjustments were made so staff had no more than 2 to 3 patients to look after, depending on level of need.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift, in accordance with national guidance. We found managers and the nurse in charge had a good oversight of ward acuity and there were escalation processes in place where safe staffing levels could not be met. Managers ensured there were enough staff with the correct skills and competencies on duty. For example, managers ensured there were a minimum of 2 Registered Nurse's Children (RNC) on duty on Skylark ward and at least 1 in the PAU. Data showed that 100% of shifts from January to March 2023, had the minimum number of RNCs on duty. On the day of our inspection, all 7 RNs on duty were RNCs.

Furthermore, we found improvements in the number of shifts where there was at least 1 RN on duty trained to the highest level of life support. During our previous inspection we found an average of 60% of shifts in the PAU were covered by a RN or RNC with European Paediatric Advanced Life Support (EPALS). This had improved and the service had an average of 97% (target 90%) of shifts on both Skylark ward and the PAU which had at least 1 EPALS trained nurse. There were 4 shifts in total where there was no EPALS trained in PAU, but this was mitigated with EPALS trained on Skylark ward where PAU is based.

The number of nurses and healthcare assistants matching the planned numbers had improved. During our previous inspection, we found the average shift fill rate in the 6 months prior to our inspection was 71% for RNs. Furthermore, on the day we inspected the service did not have the required number of RNs on duty to look after 26 patients.

Following our inspection, the service authorised the use of 2 long term temporary staff to ensure the minimal staffing levels could be achieved for RNs. This meant in addition to the permanent staff, there were 2 temporary staff on duty day and night to enable the service to meet their planned staffing levels for RNs. The service introduced an 80% fill rate target to ensure safe staffing levels could be met which they reported on weekly following our inspection.

On the day of our inspection, we found the number of RNs and HCAs met the planned numbers; from January to March 2023, 96% of RN shifts were filled. This was a significant improvement since our previous inspection. Furthermore 95% of HCA shifts were filled.

Managers utilised bank and agency staff and requested staff familiar with the service. They made sure bank and agency staff had a full induction and understood the service. During our previous inspection staff told us where shifts were unfilled, they were often filled with adult trained RNs from other areas who were not skilled or experienced in caring for paediatrics. Following our previous inspection, the service authorised the use of long-term bank and agency staff to ensure safe staffing levels could be met. They identified bank staff with paediatric competencies and utilised agencies which specialised in CYP services. The service reviewed the temporary staff induction process and implemented an induction and competency checklist. Managers audited this weekly.

During our inspection, there were 2 temporary staff on duty. Both of which were RNC trained, were familiar with the service and had undergone an induction which was documented. The induction form was completed by the nurse in charge and included an orientation to the area, a check of their current competencies, overview of escalation and emergency procedures and a handover. Managers told us this allowed temporary staff to be assigned appropriate patients based on their skill sets and were supervised by the nurse in charge. Permanent staff, both clinical and non-clinical told us there had been improvements in the use of temporary staffing and in general they had the skills and competencies required.

During our previous inspection staff and some parents that we spoke to did not consider staffing levels to be safe. During this inspection most staff told us staffing levels had improved and in general considered them to be safe. They had less patients to care for which meant more time to undertake key tasks in a timely manner such as patient observations and sepsis screens.

Parents we spoke to told us they felt their child was safe on the ward and staff were in general responsive and had time to listen to them. Feedback from parents was generally positive about the service provided.

We were therefore assured the trust action plan in response to our letter of intent was effective in implementing mitigations to ensure staffing levels remained safe. These actions enabled the service to make short to medium term improvements. Managers were in the process of reviewing staffing levels to meet future demand and to formalise the high dependency beds in use. Recruitment for permanent staff was underway.

Medicines

Staff followed systems and processes to prescribe and administer oxygen safely. Daily and weekly checks of emergency equipment and medicines were effective.

During our previous inspection we found medicines management processes were not always in line with best practice or effectively implemented. This was in relation to the prescribing and administration of oxygen and storage of adrenaline on emergency trolleys. During this inspection we found improvements had been made.

Staff followed systems and processes to prescribe and administer oxygen safely. During our previous inspection, we found where oxygen was administered, it was not prescribed in records we reviewed. Furthermore, care plans did not always include details of personalised oxygen saturation levels or required levels of oxygen. During this inspection we found improvements had been made.

Following our previous inspection, the service took immediate action to improve. Staff were required to read the trust prescribing and administration of medical gases policy. This was discussed with staff through weekly training sessions and through daily safety huddles and ward rounds. A daily compliance audit was implemented which reviewed patients on oxygen against their medicine charts and care plans. A process was implemented to ensure all medicine errors including oxygen prescribing was discussed at weekly grand round by service pharmacists and at ward meetings.

Weekly compliance audits provided to us from January to April 2023, showed an average 96% compliance with audit standards. This included compliance with oxygen being correctly prescribed by medical staff and care plans reflecting the patients personalised oxygen saturation levels and required levels of oxygen. Where there was non-compliance, all cases were discussed with individual staff and shared for learning at weekly grand round meetings.

During our inspection we reviewed 9 patient records, 2 of these patients were being administered oxygen. We found in both records, the oxygen was correctly prescribed, and the care plan was fully completed.

Services for children and young people

Daily and weekly checks of emergency equipment and medicines were effective. During our previous inspection we found out of date adrenaline on an emergency trolley on Skylark Ward. This meant there was a risk a patient could be administered out of date medicines. We also found systems and processes in place to check safe storage and use of medicines were ineffective.

Following our inspection, the service took immediate action to improve. Staff were required to read the trust resuscitation policy. This was discussed with staff at team meetings and at the weekly grand round to ensure all clinical staff were aware of the importance of undertaking a full and robust weekly check reviewing all expiry dates. A review of the robustness of emergency trolley checks was undertaken and support was provided to staff to enable them to effectively check the trolleys. The head of patient safety circulated guidance on the storage and use of adrenaline in a cardiac arrest.

During our previous inspection in December 2022, we found staff carried out daily safety checks of emergency equipment, however, they were not always effective. We found out of date adrenaline on an emergency trolley on Skylark ward. 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. We also found an emergency trolley was left unlocked and unattended.

During this inspection we checked 4 emergency trolleys (2 on Skylark Ward and 2 in the neonatal unit) and found daily and weekly checks were consistently completed and were effective in identifying equipment and medicines which were close to expiry. All 4 trolleys were locked to prevent unauthorised access. Adrenaline stored on emergency trolleys on Skylark ward and the neonatal unit were all in date and stored the correct concentration (1:10,000). We found 1:1,000 adrenaline was securely stored in medicine rooms and not on emergency trolleys. All other medicines and fluids were within the stated expiry date. However, we found emergency medicine guidance notes on an emergency trolley in the neonatal unit were out of date. Following our inspection, the service provided evidence these had been removed to ensure out of date guidance was not being followed. Furthermore, we found 1 trolley in the neonatal unit was behind a locked door which could cause a delay in accessing it in the event of an emergency. However, staff told us this trolley was not used in an emergency within neonates at the time of our inspection.

Following our inspection, we were assured the requirements of the Section 29A WN in relation to administration of oxygen and storage of adrenaline on emergency trolleys had been met.

Incidents

Managers shared lessons learned with the whole team and the wider service. Processes were in place to improve practice following incidents and monitor the implementation of learning overtime.

Systems and processes were in place to ensure learning from incidents was embedded. During our previous inspection in December 2022, we found learning from incidents was not effectively embedded. The service took immediate action to improve, and we found during this inspection improvements had been made. For example, the service implemented the following improvements to support effective dissemination of shared learning:

- Ward meeting were undertaken where themes from incidents were discussed, and action points shared.
- A standardised safety huddle template was designed and implemented so feedback from incidents, any learning and actions was communicated in a structured way. The use of the tool was audited weekly for effectiveness which showed 100% compliance since it was implemented.

- All learning points from incidents were discussed at weekly grand round meetings and consultant meetings. Grand round meetings were multi-disciplinary meetings which took place every Friday where the outgoing medical team of the week handed over to the duty medical team for the following week ahead.
- We observed learning from incidents was discussed as part of daily ward rounds.
- Monthly learning bulletins were sent to staff with an outline of incidents and learning. This included sharing where staff managed a situation well and areas for improved practice.

During our inspection, we found that there was an increased emphasis on a learning and safety culture on Skylark ward. Managers had introduced a simulation bay on the ward. The service had held simulation workshops linked to learning from previous incidents. For example, management of deterioration, sepsis, and the critically ill child. The reduced bed capacity and improved staffing levels meant staff had opportunities to attend workshops to develop their skills.

A theme identified from incidents was parents not feeling listened to by staff. As a result, the service had undertaken some focused work to increase staff confidence in listening to parents. They also seconded a complaints manager to the ward to support staff in dealing with any issues and to support parents to raise concerns. All parents we spoke to considered staff to be responsive and felt staff listened and acted on their concerns.

Weekly incident review meetings took place where all incidents were discussed, and learning identified. For example, medication errors were identified as a theme. Learning was shared with medical staff during handovers, grand round meetings and through one-to-one conversations to increase their awareness and understanding. The service implemented a weekly medicine chart audit to check compliance against medicine chart standards. From January to April 2023, audits demonstrated an average of 87% compliance with quality standards. Compliance had significantly improved from 66% at the end of January to 94% in the 3 weeks prior to our inspection. The target was 95% which had been exceeded 4 times in the 8 weeks leading up to our inspection. Feedback from audits was provided directly to medical staff which had a positive impact on quality and safety in prescribing.

Following our inspection, we were assured the requirements of the Section 29A WN in relation to learning from previous incidents had been met.

Is the service well-led?

Inspected but not rated

We did not rate this key question at this inspection. The previous rating of inadequate remains.

Management of risk, issues and performance

The Children and Young Person's quality improvement programme was effective in driving improvements. A programme of quality and safety audits was in place. Leaders used systems to manage performance effectively.

The Children and Young Person's (CYP) quality improvement programme implemented following our inspection in December 2022 was effective. The service implemented an immediate action plan in response to the Section 29A WN issued requiring significant improvement. The service undertook a series of listening events with staff and feedback was used to inform quality improvements. There were 10 workstreams in place to improve the quality and safety of services. This included all areas of concern cited in our Section 29A WN. For example, monitoring of patient observations,

identification and treatment of sepsis, safeguarding and fluid balance monitoring. A programme of weekly audits was undertaken to measure progress against each workstream. These audits were reported into a weekly CYP programme board meeting led by the Director of Nursing. Furthermore, the programme board provided regular reports on quality and safety to the executive oversight group.

Audits of quality and safety were effective in driving improvements to keep patients safe. During our previous inspection we found audits were not always completed or effective. They sometimes lacked objectivity as they were completed by staff working within the service. During this inspection we found improvements had been made. We found audits were routinely completed on a weekly basis by a variety of staff to improve objectivity. For example, some audits were undertaken by specialist staff such as sepsis nurses and matrons from other parts of the service. Weekly progress reports demonstrated managers used the audits to quickly identify non-compliance and acted to further improve.

Weekly audits demonstrated improvements had been made in performance across all areas requiring immediate improvement. The service took action to improve and provided staff with regular feedback following audits. This included one to one feedback and general feedback through ward meetings, consultant meetings, weekly medical handovers, safety huddles and ward round. Staff could describe recent feedback they had been given and told us there was 'more of a focus on service improvement'. We saw evidence of targeted education and training to improve practice such as workshops and simulation training. The service had set up a 'shared decision council' where staff led on specific service improvements.

Weekly progress reports sent to us following our previous inspection demonstrated managers took action to review cases of non-compliance to ensure patients were safe and to understand what led to the measures not being met. During our inspection, we reviewed 9 records and found there were improvements across all areas of concern cited in the Section 29A WN. What we found on inspection generally reflected performance in these audits.

Sepsis audits were in place and were effective in driving improvements. During our previous inspection, the service did not routinely complete sepsis audits to assess staff compliance with trust paediatric sepsis policies and procedures. During this inspection we found improvements had been made. The trust sepsis team and pathway to excellence lead nurse were tasked to support Skylark ward to improve practice with trust paediatric sepsis policies and procedures. They undertook weekly audits to assess compliance against these policies and fed these back to managers and staff. The service provided staff with refresher training and simulation training to improve practice. As a result, performance had improved overtime with sepsis compliance measures.

Systems to monitor safety and quality performance had improved. During our previous inspection we found Skylark ward did not have an established mechanism to review the overall quality and safety performance of the service. The service previously had a performance dashboard in place which was used to review performance and was reported to the monthly divisional governance meetings. During our inspection we found improvements had been made. Leaders we spoke to including the Head of Nursing had a robust understanding of service performance, quality, safety, and risks. Processes were in place to assess ongoing performance. The assurance template previously in place was revised to cover mandated elements of quality and safety; this recommenced from January 2023. The dashboard was submitted to the integrated governance and business meeting for monthly oversight. Key performance indicators were shared with staff and the public on ward corridors. Weekly progress reports were completed against the trust CYP improvement plan. These were reviewed internally at weekly programme board meetings and shared with stakeholders such as the Integrated Care Board (ICB). The ICB supported service improvements by undertaking regular quality visits and reviewing the service performance monthly against areas cited in our Section 29A WN.

Services for children and young people

Following our inspection, we were therefore assured the requirements of the Section 29A WN in relation to systems for improvement had been met.

Areas for improvement

Action the trust SHOULD take to improve:

Children and young persons services

- The service should ensure systems and processes to check medical air ports are covered when not in use to prevent accidental connection to air continue to be in place and monitored. Regulation 17 (1)(2)(a): Good governance.
- The service should ensure processes in place to check equipment and medicines on emergency trolleys continue to be robustly undertaken. Regulation 17 (1)(2)(a): Good governance.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector, 1 team inspector, 1 assistant inspector and 2 specialist advisors. The inspection team was overseen by Michelle Dunna, Operations Manager.