The Dudley Group NHS Foundation Trust

Russells Hall Hospital

Inspection report

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Ratings

Overall rating for this service	Not inspected

Our findings

Overall summary of services at Russells Hall Hospital

Not inspected

We carried out this unannounced focused inspection of the paediatric emergency department because we received information giving us concerns about the safeguarding of children and young people who attended the department. The paediatric emergency department saw 23,607 children in the year 2022.

The focused inspection concentrated on certain aspects under the key lines of enquiry under the safe domain. These included safeguarding, certain aspects of staffing, responding to risk and incidents.

We did not inspect any other services or key lines of enquiry as this was a focused inspection in relation to the paediatric department in urgent and emergency care only.

During the inspection we spoke with 3 patients and 15 members of staff including doctors, nurses, healthcare assistants and reception staff. We also spoke with the trust safeguarding lead and the named doctor for safeguarding.

We reviewed 23 patient records, staff rotas, safeguarding records, audits and relevant policies and procedures.

Following the inspection, we asked the trust to send us an action plan to address the concerns we raised in relation to the safeguarding of children and young people and to provide us with assurance. In response the trust provided us with a comprehensive action plan with immediate actions taken to address the concerns raised and continued with regular updates of ongoing actions.

At our last inspection we rated the trust overall and the emergency department as requires improvement overall.

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.

Urgent and emergency services

Inspected but not rated

- Systems were not always effective to ensure service users were protected from abuse and improper treatment.
- There was a lack of awareness of the cumulative impact of risk and poor consideration of known safeguarding factors to influence decisions around the child's care and treatment.
- Staff did not actively use national or locally agreed screening tools to aid in the identification of children with additional risks and vulnerabilities.
- There was a lack of professional curiosity evident within the records in addition to a lack of curiosity and proactive approach to safeguarding for children where there was known vulnerabilities.
- Staff had training on how to recognise and report abuse; however, they had not all completed it.
- The service did not have enough staff to care for patients and keep them safe or to meet recommended guidelines on staffing. However, the trust was being proactive with addressing this.

However:

- Staff regularly completed multi agency referral forms.
- The trust ensured staff received Disclosure and Barring Service checks and had a 100% compliance rate. There was an employment checks policy in place.
- A training package for paediatric staff and managing mental health in children's services was being developed.

Is the service safe?

Inspected but not rated

Safeguarding

Systems were not always effective to ensure children and young people were protected from abuse and improper treatment.Staff had training on how to recognise and report abuse, however they had not all completed it.

Staff did not always safeguard children at risk of, or suffering, significant harm.

There was a lack of interface between the children's departments and the paediatric emergency department. This meant staff in the emergency department did not always see the learning or have meaningful interactions with the paediatricians or develop relevant skills, such as being curious.

We reviewed 14 sets of patient notes in relation to safeguarding and found there was a lack of awareness of the cumulative impact of risk, and poor consideration of known safeguarding factors to influence decisions around the child's care and treatment.

There was a lack of professional curiosity evident within the records. In addition to a lack of curiosity and proactive approach to safeguarding for children where there was known vulnerabilities. Triage nurses were unable to articulate any specific ways they would assess for additional patient vulnerabilities.

Urgent and emergency services

Staff did not actively use national or locally agreed screening tools to aid in the identification of children with additional risks and vulnerabilities.

In one instance there was limited contact made with children and adolescent mental health services (CAHMS) and staff had not followed policy in relation to telephoning the local authority emergency duty team as per policy in an attempt to ensure the child's safety, when a child presented with a mental health crisis and had absconded from the ward. However, the ward did make contact the police and followed up with a multi-agency referral form (MARF).

A child on a protection plan that presented in the emergency department but did not wait to be seen was incorrectly coded on the electronic patient record. This meant that this child was not brought to the attention of senior staff to ensure they were followed up appropriately.

Processes were in place to identify children who were on a child protection plan. The child protection information sharing system was checked by the receptionists for each child. If a positive entry was found the details of the plan were pulled through. There was also an alert if the child had attended the department more than 3 times.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. However, not all staff had completed it. Safeguarding adults and children's training did not meet the trust target rate of 90%. For example, 83% of staff had completed safeguarding children level 2 training, 79% had completed level 2 adults safeguarding training and 70% had completed level 3 safeguarding children's training.

Junior doctors had been incorrectly listed as requiring level 2 safeguarding training instead of level 3. This affected 4 staff members who leaders told us would be compliant with level 3 by March 2023. The safeguarding team were planning some one-off additional training for level 3 safeguarding training via teams. Safeguarding training compliance was on the departmental risk register.

Security officers were employed by an external contractor. Security officers had training in conflict management and physical intervention, and safeguarding.

Safeguarding understanding was varied. Some staff were able to articulate how they would manage any safeguarding concerns, others were unable to give examples of safeguarding concerns, articulate the reasons for previous MARFs or provide us with any further details on the content of the trusts safeguarding training.

There was a lack of awareness amongst staff of written action plans or reports in relation to previous safeguarding incidents.

There was a safeguarding children's policy in place which explained the roles and responsibilities of staff. However, staff did not always follow this. Additionally, there was a bruising and injuries in non-mobile children and imaging for children with suspected non-accidental injuries standard operating procedure in place. The trust also provided staff with some additional training around non-accidental injuries in children. Training dates were also in place to provide training around non-accidental bruising.

We saw patient safety and experience bulletins around non-accidental injuries in children and making safeguarding personal. The bulletins included what safeguarding practitioners should consider, using professional judgement and what to look out for.

Urgent and emergency services

The paediatric emergency department had a child protection information sharing system in place. When a child was assessed to be at risk the process was, they would go to a place of safety which staff told us was the children's ward.

There was a child protection rota in place. The named doctor for safeguarding had limited time capacity to carry out their safeguarding duties. However, on the day of the inspection leaders told us how they recognised this and were taking steps to address this.

The paediatric emergency department had a safeguarding champion in place. Their role was to facilitate education and training within the team, to be a point of contact for the trust safeguarding team and a link between all areas of the emergency department.

Leaders told us they had registered for the child protection service delivery standards audit around child protection medicals.

The trust ensured staff received Disclosure and Barring Service checks and had a 100% compliance rate. There was an employment checks policy in place.

CAHMS were commissioned to attend the emergency department, however, although they had a 24-hour helpline at the time of the inspection they did not visit out of hours.

The trust had an agreed and formalised service level agreement with the local mental health team to have overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of Mental Health Act documents. Additionally, to have a lead role in maintaining processes and systems to support compliance with the Mental Health Act and code of practice in joint partnership with the trust Mental Health Lead.

There was a restrictive intervention for children and young people guideline in place which included information around restraint and rapid tranquilisation. There was also an emergency department clinical standard operating procedure in place which included the process in relation to the management of patients who did not wait to be seen.

At the time of the inspection a training package for paediatric staff and managing mental health in children's services was being developed with the plan to commence the training in April 2023. This had been highlighted as a required training need due to an increase in mental health crisis amongst children and young people. The 2-hour training package would include areas such as safeguarding considerations. Safety planning, self-harm and care planning. In the interim the mental health team were developing a brief package to deliver from March 2023.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff regularly completed MARFs to report safeguarding concerns. Leaders monitored the amount of MARFs submitted. Between October 2022 and January 2023, the department submitted 510. Leaders also monitored the number of delayed MARFs which had been identified through the paediatric liaison nurse; between these same dates 61 were found to have been delayed.

Staff had created a safeguarding board in the paediatric emergency department waiting area. The board had information and contact numbers for patients on sexual exploitation, domestic violence and youth violence.

Assessing and responding to patient risk

Staff completed risk assessments when required in line with national guidance. However, the trusts internal audit processes showed improvement was required in completing escalation documents and senior clinician reviews.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff followed the Royal College of Paediatrics and Child Health (RCPCH) standards in relation to triage in the paediatric emergency department. We reviewed a sample of patient records and saw staff used the Paediatric Early Warning Score (PEWS) when required.

There was a standard operating procedure in place around the PEWS. The standard operating procedure contained guidance on PEWSs and actions to take, such as screening for sepsis or requesting a medical review.

The electronic recording system automatically defaulted to the correct assessment tool depending on the age of the patient. Staff then inputted the observations and the electronic system calculated the PEWS.

The trust had a deteriorating patient pathway assurance dashboard in place. Results showed improvement was required in completing escalation documents and senior clinician review.

Leaders monitored triage performance in the paediatric emergency department. The latest results showed between the 25 December 2022 and 5 February 2023, the trust did not meet the target rate of 95% for assessment within 15 minutes. Compliance ranged between 78% and 89%.

The process for children and young people who attended the department was that all children were initially seen and assessed by the streaming nurse in the urgent care centre, which was managed by another provider. Depending on the child or young person's presenting needs the child would then either be streamed to the urgent care centre managed by another provider to see a doctor or to the trust's emergency duty team reception desk. The reception desk then telephoned the paediatric department to inform them of the arrival of the child. The process was that all children would then receive an initial assessment when they arrived at the paediatric emergency department.

There were escalation processes in place. In line with the emergency severity algorithm any patient triaged as high risk would be discussed with the allocated emergency doctor. There was also a paediatric emergency department operational issues escalation process in place.

There was a paediatric head injury nurse led discharge standard operating procedure in place. The procedure had been written to help facilitate the assessment of minor head injuries at triage or paediatric patients presenting at the emergency department.

The trust did not have a named sudden unexpected death in childhood (SUDIC) paediatrician. The process was the on call general paediatrician managed any SUDIC cases presenting to the emergency department. There was also a designated doctor for child death at the Dudley integrated care board who supported the team for emergency advice. The trust had a designated nurse for child mortality.

The service completed audits to in relation to RCPCH. We saw audits had been completed on head injury in children, paediatric triage and pain in children. Paediatric triage next steps included reviewing triage capability to improve key performance indicator (KPI) compliance and reviewing the strategy to improve KPI's for minor injuries. Next steps for pain in children were to audit the impact of the paediatric waiting room poster on pain regarding assessment and to re audit the entire pathway.

Urgent and emergency services

Staff told us how they had regular huddles where they shared key information. Staff told us they had huddles where they discussed information, such as incidents and complaints. However, leaders did not keep any written evidence these or a register of who had attended. Leaders told us they recognised this needed to be put into place. No handover sheets with patient information were available to review on the day of the inspection.

Nurse staffing

The service did not 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 staff including bank and agency a full induction.

The service did not have enough nursing staff to keep patients safe. On the day of the inspection the paediatric emergency department was fully staffed with 3 trained nurses and 1 care support worker. Leaders told us they based staffing levels on the Royal College of Nursing and the RCPCH guidelines.

We reviewed nurse staffing information in relation to February 2023. This showed 17 out of 28 shifts had less than 2 registered children's nurses on shift. In all cases the unfilled shifts had been escalated to bank and agency staff, but the shifts remained unfilled. Support was also requested from the children's ward, but they were unable to provide the additional staff.

Leaders told us all staffing shortages were discussed with relevant senior staff with consideration given to the capacity and acuity in the emergency department.

The number of nurses and healthcare assistants did not match the planned numbers. Between 30 January and 26 February 2023, the department was recorded as being understaffed on 53 occasions and overstaffed on 1 occasion. We noted staffing was on the departmental risk register.

The service had reducing vacancy rates. At the time of the inspection the paediatric emergency department had 2 band 6 vacancies and 2 band 5 vacancies which were out for advert.

Leaders were being proactive in the process of recruiting of nursing staff and spoke of recruitment events, training and development programmes, inviting prospective staff for tours of the hospital and how they had taken on some international recruits.

The trust were taking action to address the shortage though various ways including also working with the children's wards to look at rotation posts, attending a recruitment event and making an interactive video to be used to advertise on social media platforms. They were also looking into an 18-month conversion programme that could be offered to registered nurses wanting to convert to a registered children's nurses.

The service monitored sickness and turnover rates. The turnover rate for nursing staff at the time of the inspection was 7%. The sickness rate for nursing staff at the time of the inspection was 11%.

The service used bank staff to fill in any gaps. From the 30 January to the 26 February 2023, the number of bank filled duties for registered staff was 38 (55%) and 0 (0%) for agency filled.

Managers made sure all staff had a full induction and understood the service. New starters were allocated 4 weeks supernumerary and were not counted as part of the staffing numbers. Each new staff member was allocated a mentor or buddy who they worked alongside for support and coaching.

The trust had an inhouse professional development nurse who worked clinically with new starters to support completion of competencies. We reviewed a staff induction folder which contained local ward inductions for registered, staff bank staff and agency staff. The induction process included familiarisation with fire procedures, met calls, manual handling, infection prevention control, resuscitation and manual handling.

Medical staffing

The service had vacancies for medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had vacancies for medical staff. There was a named paediatric emergency department consultant on the rota from 8am to 4pm and from 4pm to 10pm.

The service always had a consultant on call during evenings and weekends.The named consultant for paediatric carried a bleep to ensure they were available for advice in case handling any clinical or managerial issues away from the paediatric main areas in the main emergency department.

The name and bleep number was updated regularly in the paediatric area. From 10pm to 8am the bleep was held by the emergency duty registrar to support the medical and nursing team if required during the night.

The emergency department had 2 consultants who were dual accredited with paediatric emergency medicine and who closely engaged on paediatric clinical and managerial engagements.

Leaders told us they had identified named consultants on rota who were responsible to oversee clinical and managerial work in the paediatric emergency department on weekdays from 8am to 10pm. Consultant supervision also extended to weekends from 11am to 7pm.

The trust had increased consultant numbers over the last 3 years in the emergency department. There was planned meetings with the divisional financial team to explore further expansion of consultant tier which would include predominantly paediatric emergency medicine trained consultants.

A shortage of emergency department middle grade doctors was noted on the departmental risk register.

The service had low and/or reducing vacancy rates for medical staff. At the time of the inspection there was 5 advanced clinical practitioner vacancies, 2 senior house officer vacancies and 1 middle grade vacancy.

The service had high turnover rates. The turnover rate for medical staff, including doctors on rotation was 22%.

Sickness rates for medical staff were low. The sickness rates for medical staff was 3%.

The service monitored rates of bank and locum staff. Records showed there had been 52 senior house officer bank shifts in January 2023, with 3 unfilled and 58 in February 2023, I with 1 unfilled. For middle grade doctors there had been 100 bank shifts in January 2023, and 75 in February 2023, 13 agency shifts in January 2023, and 5 in February 2023, none of the shifts were unfilled.

Managers could access locums when they needed additional medical staff. The trust did not use any agency senior house officers and only used 2 long term agency members of staff who had been working in the department for 3 years

Urgent and emergency services

Incidents

Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff recorded incidents on the trusts electronic recording system.

We reviewed the incidents that had been reported between November 2022 and January 2023 and found the main themes were in relation to workforce and medicines. Other categories of incident included appointments and discharge, clinical treatment failures, diagnostic tests, records and communication.

Learning from incidents within the department was varied, some staff were able to share learning from incidents and some were not. Staff told us they discussed incidents at daily huddles.

The service had no recent never events in the paediatric emergency department in 2022.

Managers investigated incidents. We reviewed a root cause analysis report and found it considered lessons learnt, key recommendations, involvement of other services and contained an action plan with clear dates for completion. The action plan was colour coded red, green or amber depending on the risk ratings.

The trust held monthly mortality and morbidity meetings to review all critical incidents and deaths. We saw feedback was shared with staff via the emergency department newsletter.

Managers debriefed and supported staff after any serious incident. We reviewed a 72-hour report and saw staff had been debriefed following an incident.

There were policies in place for external clinical effectiveness reports (management of) guidelines and the central alerting system.

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:

The trust MUST ensure that:

Regulation 13 Safeguarding service users from abuse and improper treatment is met, including:

- Service users are protected from abuse and improper treatment.
- Systems and processes are established and operated effectively to prevent abuse of service users.
- Systems and processes are established and operated effectively to investigate, immediately upon becoming aware of, any allegation of such abuse.

Urgent and emergency services

Action the trust SHOULD take to improve:

- The trust should ensure that they continue to work towards recruiting enough medical and nursing staff to keep patients safe and meet recommended staffing guidelines for the paediatric emergency department.
- The trust should ensure they continue to improve results in relation to completing escalation documents and senior clinician reviews in deteriorating patients.
- The trust should continue to improve triage times in line with national guidance.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a children's CQC inspector and a specialist advisor with experience in children's safeguarding. 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