University Hospitals Sussex NHS Foundation Trust

Royal Sussex County Hospital

Inspection report

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Date of inspection visit: 19 December 2022
Date of publication: 08/03/2023

Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Sussex County Hospital

Inspected but not rated

We carried out this unannounced focused inspection of the childrens emergency service at Royal Sussex County Hospital because we received information giving us concerns about the safety and quality of the service.

How we carried out the inspection

We looked at 22 patient records, observed activity in the department, spoke with three members of staff and reviewed data provided by the trust.

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

- The service did not have enough staff to care for patients and keep them safe. Staff did not always complete patient assessments in a timely manner. Staff did not always update assessments and there was risk that staff would not identify and quickly act upon patients at risk of deterioration. Some areas of the environment did not fully protect people from risk of harm.

However:

- Staff took action to safeguard patients from abuse. Staff acted to reduce the risk of avoidable harm to children who had mental health illnesses

Is the service safe?

Inspected but not rated

Safeguarding

Staff took action to safeguard patients from abuse.

Patient records evidenced staff identified potential safeguarding concerns and reported potential safeguarding risks to the relevant practitioners and authorities to protect children and young people from abuse.

There was evidence in the records that staff monitored and acted when children repeatedly attended the department. These children were referred to the paediatric liaison team for a follow up contact. This meant staff were actively identifying potential risk and safeguarding children from the risk of abuse.

Environment and equipment

Some areas of the environment did not fully protect people from risk of harm.

Within the main atrium of the childrens hospital there was a glass balcony overlooking the atrium. Although this balcony area was not in the childrens emergency department, there was still potential risk that a child could leave the ground floor emergency department to walk round to the main entrance of the children's hospital where the nearest café was situated, see the balcony and decide to jump/throw toys off. The lifts to the balcony areas were accessible with no security restrictions.

The crash trolley in the department was not secured with a tamper proof tag. This meant that in the event of an emergency situation, the service could not be assured staff had quick access to all necessary equipment. This was raised with staff and they took immediate action to rectify this

The waiting area was small. Although size of the waiting area did not pose a risk to the safety of patients, it did not support a positive patient experience.

Assessing and responding to patient risk

Staff did not always complete patient assessments in a timely manner. Staff did not always update assessments and there was risk that staff would not identify and quickly act upon patients at risk of deterioration. However, staff acted to reduce the risk of avoidable harm to children who had mental health illnesses.

Urgent and emergency services

Staff did not always assess patient's health in a timely manner. National guidelines detail that all patients should have an initial clinical assessment completed within 15 minutes of arrival at the department. Data provided by the trust showed this did not always happen. The data showed the median and average time for staff to carry out an initial assessment of the patient had increased (got worse) over the three months of October, November and December 2022. The median time for staff to carry out an initial assessment did not meet the national target for October and December 2022. Of 28 children and their families that we either spoke with or reviewed records during the day of the inspection 16 out of 28 had an initial assessment carried out within 15 minutes of arrival at the department. However, no child waited over 25 minutes and staff showed commitment to carrying out the initial clinical assessment in a timely manner as possible on a day when the childrens emergency department was extremely busy. This was due to a national surge in children's attendances emergency departments caused by a high prevalence of Group A Streptococcus. The department was seeing 50% more patients daily than usual for the time of year.

There was potential risk of avoidable harm to patients who had received an initial assessment but had not been seen by a doctor in a timely manner. Staff carrying out the initial clinical assessment used a triage tool that identified timescales patients needed to be seen by a doctor according to the severity of their conditions. However, patients experienced long waits to be seen and reviewed by medical staff. Data provided by the trust showed that the median time for patients to be seen by medical staff had increased through the months of October, November and December 2022. On the day of the inspection the department displayed there was a waiting time of 5 hours. Two out of three parents told us their child waited for a long time to see a doctor. One had waited 7 hours and the second had waited over 3 hours and had not yet seen a doctor. However, the third parent said their child had been seen quickly by a doctor. Of 138 patient casualty cards we reviewed for the date of 6 December 2022 the time for doctors to review patients ranged from 2 hours to 11 hours.

Staff did not always update assessments and there was risk that staff would not identify and quickly act upon patients at risk of deterioration. Staff used a nationally recognised tool to identify deteriorating patients. However, staff did not always review patients' conditions while they were waiting be seen by medical staff. Casualty cards for 6 December 2022 showed staff did not check patients' observation for several hours following initial assessment. For one patient, whose record showed they had received an initial assessment at 6.38pm, had no further assessment or observations completed unit after they were seen by the doctor at 4.30am the following day. After they had been seen by the doctor, staff carried out observations of this patient every hour.

There was lack of evidence that staff always acted to reduce risk of avoidable harm to patients who left the department without being seen by a doctor. The service did not have a policy about what staff should do if a child left the department without being seen, but there was a flow chart that detailed action staff should take. However, there was little evidence in patient notes that staff always followed this process. Records showed that on 6 December 2022 the department saw 140 patients in 24 hours. Of these, 26 (19%) patients left the department without medical review. Review of 22 patient notes showed that for 3 patients who left the department without being seen there was no evidence in their notes to demonstrate staff had followed the guidance of the flow chart. There was no clear information for parents about expected waiting times, or what to do if they decided to leave the department before their child was seen by a doctor. There was only one sign asking parents to make staff aware if they decided to leave. The sign was on the automatic doors and was not visible from the waiting room or when leaving the department.

However, staff acted to reduce the risk of avoidable harm to children who had mental health illnesses. Patient records demonstrated staff appropriately sought advice and attendance of children's mental health service staff.

Nurse staffing

The service did not have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Urgent and emergency services

The service did not have enough nursing and support staff to keep patients safe. Information CQC received before the inspection indicated there were insufficient numbers of nursing staff to ensure a safe service. The trust said that annual reviews of the nurse staffing establishment were carried out and staffing numbers changed as needed. However, this was not recognised by staff, who told us the planned staffing numbers were based on a staffing template last reviewed in 2012 which no longer met the needs of the volume and acuity of patients presenting at the department. The trust had recently recognised that further changes to the staffing establishment were needed. In December, prior to the unannounced, visit a business case investing in nurse staffing was approved by the trust executive.

The number of nurses and healthcare assistants did not always match the planned numbers. Data provided by the trust showed that the planned number of childrens nurses on each shift was set at 4. The data showed that between 1 October 2022 and 8 December 2022 there were 30 out of 69 shifts when there were more than 4 childrens nurses on each shift, ranging between 5 to 8 childrens nurses. There were 8 shifts where there were only 3 childrens nurses on the day shift. For the night shift the 41 shifts when there were more than 4 childrens nurse working and only 3 where there were less than 4. However, as there was no up to date template for the required numbers of staff, the service could not be assured these numbers of staff actually met the needs of the service.

The trust said that for the period October, November and up to 8 December 2022 there was, on average, 3 band 6 childrens triage nurses carrying out the initial clinical assessments on the day shifts and 3.5 on the night shift. However, on the day of the inspection there was 1 triage nurse who was a band 5. They said that ideally, they would like 2 triage nurses, but if a second was provided, this would take nurses away from other areas in the department.

Medical staffing

The service did not always have enough 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 in a timely manner.

The service did not always have enough medical staff to always keep patients safe. Although medical staffing mainly met the planned numbers, delays for patients being assessed and seen by medical staff indicated there were insufficient numbers of medical staff to meet the needs of patients in a timely manner, particularly at times of high demand.

However, the medical staff on duty matched the planned number and the recommendations about medical staffing of the Royal College of Paediatric and Child Health (RCPCH) published Facing the Future: Standards for children in emergency care setting.

Data provided by the trust showed there was a varying number of junior doctors of various grades and experience rostered to work in the childrens emergency department. Actual numbers mostly met the planned numbers. However, it was not clear how the numbers were planned as there were varying numbers rostered to work each day with no clear pattern.

Areas for improvement

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

Action the trust MUST take to improve:

Urgent and emergency services

Urgent and Emergency services – Childrens emergency department

- The trust must ensure that there are enough numbers of staff of all roles and grades on duty to meet the needs of patients. (Regulation 18)
- The trust must ensure the children are assessed and treated in a timely manner. (Regulation 12)

Action the trust SHOULD take to improve:

Urgent and Emergency services – Childrens emergency department

- The trust should ensure the environment of the childrens emergency department does not pose any risk of avoidable harm to people. (Regulation 12)
- The trust should ensure that children's health and conditions are kept under review while waiting to be seen by medical staff. (Regulation 12)
- The trust must ensure information is available to parents/carers informing them what to do if they decide to leave the department without the child or young person receiving a medical or nursing review. (Regulation 12)

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 2 other CQC inspectors. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation