Mid Essex Hospital Services NHS Trust

Broomfield Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

Mid Essex Hospital Services NHS Trust employs nearly 5,000 members of staff and provides local elective and emergency services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree (including Witham).The trust provides from five sites in and around Chelmsford, Maldon and Braintree. The main site is Broomfield Hospital in Chelmsford.

Broomfield Hospital is an acute 635 bedded hospital. Broomfield hospital also provides a country-wide plastics, head and neck and gastrointestinal (GI) surgical centre to a population of 3.4 million and an internationally recognised burns service at the St Andrews Centre that serves a population of 9.8 million.

We completed a focussed inspection on the 30th January 2017 following a Statutory Notification, to ensure that the trust had implemented the action plan to mitigate the risk of a serious incident reoccurring in the peadiatric Emergency Department. The peadiatric ED department had been reconfigured in 2016 to sit within the Womens and Childrens Directorate as part of the trusts action plan.

This was undertaken by two CQC inspectors and one specialist advisor. Only peadiatric services in the Emergency department (ED) at Broomfield Hospital were inspected. We have not rated this service as it was a focused inspection to review the actions taken by the trust in respect of this incident.

The inspection team made an evidence judgement on one domain to ascertain if services were safe.

We found:

- There was good evidence of lesson learned from incidents that had taken place and where changes had been made in practice and embeded.Due to the reconfiguration of the peadiatric ED department to the womens and childrens directorate, risks and incidents were discussed at a number of meetings and shared across the whole peadiatric pathway.
- There was a dedicated safeguarding peadiatric lead. Safeguarding Level three training had been expanded to include all Health Care Assistants in the ED department, and 100% of staff had completed Level 1 and Level 2 safeguarding childrens training.
- The Children's Early Warning Tool (CEWT) training and sepsis training had been embedded in paediatric basic life support and paediatric immediate life support (PILS), which was part of the mandatory training programme, meaning that all staff (not just in paediatric ED), had been trained in the management of the unwell child.
- The Children's Early Warning Tool (CEWT) was in line with national guidance and in line with the observations parameters outlined in the children's and young people observation policy.
- There was a clear escalation pathway at the back of all observation charts, which included the use of the "SBAR" tool (situation, background, assessment and recommendation) to assist staff when escalating concerns.
- Sepsis workshops had been rolled out to all medical and nursing staff to develop competencies in recognising and responding to children with sepsis. This included the importance of concerns raised by parents about their child's condition.
- Nurse vacancies had been recruited to although there was still a reliance on agency and bank staff to maintain staffing levels. Due to the reconfiguration of the peadiatric ED department to the womens and childrens directorate, staffing was reviewed daily, or as required by the peadiatric matron and clinical lead to ensure that staffing across with whole peadiatric pathway was safe.
- There was no specialist paediatric ED consultant, however the trust was trying to recruit to this post. Between April 2015 and March 2016, the emergency department saw over 16,000 patients that were less than 17 years of age. The Royal College for Emergency Medicine (RCEM) recommends that in emergency departments seeing more than 16,000 children per year there should be at least one paediatric emergency consultant. The trust does have a consultant with an interest in paediatrics, but overall the trust did not meet this standard.

Summary of findings

- There was ongoing recruitment to have a second peadiatric registrar to support the ED registrar 24 hours per day. Although these posts were not fully recruited to, any vacant shifts were put out for locum cover. However, during the period 2 January 2017- 29 January 2017 14 shifts for the second paediatric register had remained unfilled
- Data on major incident training provided by the trust showed that 12 of the 14 nursing staff in the paediatric emergency department had completed this.

We noted that there were good areas of practice and also areas where the trust should continue to make improvements.

The trust should:

- Continue to recruit the specialist paediatric ED Consultant post to be in line with the Royal College for Emergency Medicine guidance.
- Continue to recruit to peadiatric Registrar vacancies to allow 24/7 additional support to the ED registrar.
- To ensure that the completion of the "safe to discharge" check is completed in all patient records by the medical teams.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Broomfield Hospital

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Detailed findings

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Background to Broomfield Hospital

Mid Essex Hospital Services NHS Trust was established as an NHS trust in 1992. The trust provides local elective and emergency services to 380,000 people living in and around the districts of Chelmsford, Maldon and Braintree.

The trust, based in the city of Chelmsford in Essex, employs over 3,800 staff, and provides services from five sites in and around Chelmsford, Maldon and Braintree. The main site is Broomfield Hospital in Chelmsford, which has been redeveloped as part of a £148m private finance initiative (PFI). The trust provides the majority of services at the Broomfield Hospital site.

Our inspection team

Our inspection team was led by an Inspection Manager

The team included two CQC inspectors and a specialist advisor in Emergency care.

How we carried out this inspection

We completed a focussed inspection on the 30th January 2017 following a Statutory Notification, to ensure that the trust had implemented the action plan to mitigate the risk of a serious incident reoccurring in the peadiatric Emergency Department. The peadiatric ED department had been reconfigured in 2016 to sit within the Womens and Childrens Directorate as part of the trusts action plan.

Urgent and emergency services

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	**Requires improvement** 

Information about the service

The urgent and emergency services at Broomfield Hospital are located within the private finance initiative funded (PFI) wing of the hospital, which was purpose-built and opened in 2010. Broomfield Hospital had 91,047 attendances to their emergency department between April 2015 and March 2016, 19,923 attendees were under 17 years of age.

The emergency department is a member of a regional trauma network and offers immediate emergency and urgent care to the patients of Mid Essex providing a 24 hour, seven day a week service. The department has facilities for assessment and treatment of minor and major injuries and illness with 15 major cubicles, four resuscitation spaces, dedicated children's area, emergency nurse practitioner (ENP), and general practitioner (GP) led services. The emergency department includes an emergency assessment unit (EAU) with 30 beds; its purpose is to support patients who can be managed in a short stay environment without the need for onward admissions or an extended stay in hospital. There is an ambulatory care unit (ACU), situated adjacent to the EAU that receives patients via the ED and GP referral. The emergency senior assessment team (ESAT), used a four-bedded bay adjacent to the ACU to triage patients who arrived via the ambulance bay.

Summary of findings

We found:

- There was good evidence of lesson learned from incidents that had taken place and where changes had been made in practice and embeded.Due to the reconfiguration of the peadiatric ED department to the womens and childrens directorate, risks and incidents were discussed at a number of meetings and shared across the whole peadiatric pathway.
- There was a dedicated safeguarding peadiatric lead. Safeguarding Level three training had been expanded to include all Health Care Assistants in the ED department, and 100% of staff had completed Level 1 and Level 2 safeguarding childrens training.
- The Children's Early Warning Tool (CEWT) training and sepsis training had been embedded in paediatric basic life support and paediatric immediate life support (PILS), which was part of the mandatory training programme, meaning that all staff (not just in paediatric ED), had been trained in the management of the unwell child.
- The Children's Early Warning Tool (CEWT) was in line with national guidance and in line with the observations parameters outlined in the children's and young people observation policy.
- There was a clear escalation pathway at the back of all observation charts, which included the use of the "SBAR" tool (situation, background, assessment and recommendation) to assist staff when escalating concerns.

Urgent and emergency services

- Sepsis workshops had been rolled out to all medical and nursing staff to develop competencies in recognising and responding to children with sepsis. This included the importance of concerns raised by parents about their child's condition.
- Nurse vacancies had been recruited to although there was still a reliance on agency and bank staff to maintain staffing levels. Due to the reconfiguration of the peadiatric ED department to the womens and childrens directorate, staffing was reviewed daily, or as required by the peadiatric matron and clinical lead to ensure that staffing across with whole peadiatric pathway was safe.
- There was no specialist paediatric ED consultant, however the trust was trying to recruit to this post. Between April 2015 and March 2016, the emergency department saw over 16,000 patients that were less than 17 years of age. The Royal College for Emergency Medicine (RCEM) recommends that in emergency departments seeing more than 16,000 children per year there should be at least one paediatric emergency consultant. The trust does have a consultant with an interest in paediatrics, but overall the trust did not meet this standard.
- There was ongoing recruitment to have a second peadiatric registrar to support the ED registrar 24 hours per day. Although these posts were not fully recruited to, any vacant shifts were put out for locum cover. However, during the period 2 January 2017- 29 January 2017 14 shifts for the second paediatric register had remained unfilled
- Data on major incident training provided by the trust showed that 12 of the 14 nursing staff in the paediatric emergency department had completed this.

Are urgent and emergency services safe?

Incidents

- There were 62 incidents reported in emergency paediatrics in the six months prior to our inspection. Of these, 24 were categorised as staffing issues. None were graded as resulting in severe harm; one resulted in moderate harm.
- There was a strong culture of learning from incidents within the department. For example, the senior nurse and agency nurse we spoke with were able to explain the lessons that had been learned and changes made following an investigation into a case of sepsis in a child admitted to the department. This showed there were systems in place to share actions and learning from incidents to minimise the risk of similar events reoccurring.
- Incidents were discussed monthly and "hot topics" would be produced to enable to share learning across all of the paediatric services. For example a recent "hot topic" was ensuring that medications were written oral or intravenous and not as an interchangeable prescription.
- Learning from incidents was shared via email, and sisters' meetings, safety huddles and ward meetings to ensure all staff were made aware. Incident reports, once investigations had been completed, were discussed at the Children's Urgent and Emergency Care Group which reported to the Patient Safety Group.
- We reviewed an investigation of an incident that had occurred in September 2016 relating to a child with sepsis requiring admission to the paediatric intensive care unit (PICU). The appropriate root causes had been identified and there was evidence that duty of candour had been applied, with the patient's mother being offered a face-to-face meeting about the findings of the investigation. Action plans had been set out within the investigation report. The investigation showed that observations had been carried out accordance to guidance and that the sepsis patient pathway had been followed.
- We reviewed minutes from clinical quality review group meetings in January 2017 and July 2016 which reviewed paediatric incidents. There was evidence of identifying key risks and actions taken for each example discussed.

- Mortality and morbidity data provided by the trust showed that for the year 1 January – 31 December 2016 there were five cases of children who died in the department or were deceased on arrival to the department. The cases had been discussed at the mortality and morbidity meetings. Learning actions were recorded, such as ensuring that all new doctors received the policy for the management of the deteriorating child.

Cleanliness, infection control and hygiene

- The paediatric area of A&E was visibly clean and we saw staff regularly using the hand sanitisers available and using personal protective equipment (PPE) to minimise the spread of infection.

Environment and equipment

- One major accidents cubicle could be accessed by both general A&E and the children's side, through separate doors; however at the time of our inspection this was not locked meaning there was access into the children's area.
- The second majors cubicle was usually used for patients presenting a higher risk of infection.
- There were two triage rooms and a dedicated children's waiting room which was equipped with books and wipe-clean toys for younger patients.
- There was a plaster room which could also be used as a general cubicle when the department was busy and lacked space. Oxygen and suctions were available in this room in case of this.
- There was one dedicated paediatric resuscitation cubicle within the resuscitation area, which was also used for adult patients when the adult bays were at full capacity. There was also a designated cubicle for neonates and emergency deliveries. We saw the utility room which could be accessed by both the adult and children's areas of the department and was well organised and free from clutter; however at the time of our inspection the key code door from this room to the adult area of the department was unlocked.
- We checked equipment in the neonatal resuscitation trolley and the paediatric airway trolley in the department. The checks on the trolleys were complete and up-to-date; however when we checked the contents of the neonatal trolley, we found that one size zero face mask on the neonatal trolley was out of date (September 2015) and one size zero Guedel airway on the paediatric trolley was out of date (August 2015). We flagged this up to the nurse in resuscitation at the time.
- All portable appliance testing (PAT) for the equipment we inspected in the department was within date.

Medicines

- The department did not have a dedicated pharmacist.
- The medicines storage room was organised and secured with keypad access.

Records

- Patient records were paper-based. During the inspection we reviewed 25 sets of notes retrospectively from the documentation audit.
- Overall documentation was good, however eight records showed that the signing off of the "safe for discharge" section had not been completed by medical staff. This was fed back to the senior team at the time of inspection.

Safeguarding

- There was a dedicated safeguarding paediatric lead.
- Alerts to safeguarding concerns or children on protection plans were recorded on the electronic patient system. Due to different systems used, information was not always shared through the computer systems and relied on staff ensuring that information had been recorded appropriately. However, the trust was upgrading their computer systems in May 2017, which would allow for a more integrated electronic patient medical record.
- The safeguarding team visited the department daily, although not on weekends, to check children's records. Records of patients over the weekend would be collected and reviewed by the safeguarding team the following Monday.
- The department and staff had good links to the trust's safeguarding lead nurse.
- Daily safety huddles included discussion of any safeguarding concerns; these were carried out jointly between the children's and adults' areas.
- Safeguarding training compliance for level three safeguarding children was flagged as red on the mandatory training records as it was 73.3%, which was below the 95% target. However, this was because level

three safeguarding had recently been expanded to include health care assistants working in the ED department. We saw that staff had been booked into sessions in February and March 2017. All staff had completed children's safeguarding levels one and two.
- The band seven nurse had also completed a recognised children's training programme, which provided additional support to staff.

Mandatory training

- Mandatory training compliance for emergency department paediatrics was 91.7% overall across 14 members of staff, as of January 2017.
- The Children's Early Warning Tool (CEWT) training and sepsis training had been embedded in paediatric basic life support and paediatric immediate life support (PILS), which was part of the mandatory training programme, meaning that all staff (not just in paediatric ED), had been trained in the management of the unwell child.
- Competencies in triaging emergency paediatric patients were signed off by senior paediatric nurses.

Assessing and responding to patient risk

- The Children's Early Warning Tool (CEWT) was in line with national guidance and in line with the observations parameters outlined in the children's and young people observation policy.
- There was a clear escalation pathway at the back of all observation charts, which included the use of the "SBAR" tool (situation, background, assessment and recommendation) to assist staff when escalating concerns. At the time of the inspection, there were no children in the department that had 'triggered' on the CEWT scoring, so we were unable to see if escalation had been made appropriately.
- The senior nurse in charge of paediatrics within A&E explained the process for initial assessment and triage of patients depending on whether they arrived by ambulance or as a walk-in. This system was well managed with a consultant or senior nurse always based in the ambulance arrival area to assess patients.
- There was an escalation policy in place if a child was admitted that required resuscitation and all resuscitation bays were occupied. We were assured that in the event of unexpectedly high need for resuscitation beds, the department would be able to flex up in terms of capacity and staffing as best as they could with the available resources.
- In the event that a child did need to be held in an adult area owing to capacity, a children's nurse would always be with them to ensure safety.
- There was a standard operating procedure, which provided clear guidance and escalation process for the management of the deteriorating child.
- There were twice-daily 'safety huddles' to flag any concern about the patients most at risk in the department.
- We saw that communications were good between nursing and medical staff and also between hospital and ambulance staff, to assess, triage and respond to patient risk as safely as possible.
- For the past 12 months there had been a sepsis workshop to improve staff skills and competencies in recognising and responding to potential sepsis cases. Fifty per cent of the paediatric team within the department had completed the training, with the remainder of the team booked onto upcoming sessions. The workshop was done jointly for nursing and medical staff and included a discussion of 'live cases' that had occurred at the hospital, learning from incidents and the most up-to-date national guidance on recognising and managing sepsis.
- We saw an up-to-date policy, 'Early Identification and Management of Severe Sepsis and Septic Shock in Children and Young People' that had been developed in response to national best practice. This included the paediatric sepsis screening and action tools for the three different age groups and the Children's Acute Transport Service (CATS) flowchart for the first hour of sepsis, which the senior nurse in the department was able to explain clearly.
- We spoke with one member of agency staff working in the department who was able to explain the lessons learned from the sepsis workshop. This included a better awareness and acknowledgement of any concerns raised by parents about their child's condition; and a focus on rapid escalation and communication between the nursing and medical teams if there was any doubt as to a sepsis risk.

Nursing staffing

- Between 2 and 29 January 2017, nursing shifts filled by agency staff within the paediatric emergency department ranged from 0% (on seven of the 28 days) to 34.9%. The department used no bank staff on seven of the 28 days and the highest use of bank staff was 28.7%. On three of the 28 days all shifts were filled by the department's own nursing staff.
- The senior nurse told us that while they were still relying on agency and bank nursing staff to cover shifts, they were usually able to cover these using a core group of agency and bank staff who were familiar to the department. Agency and bank staff received trust and local induction to familiarise them with the department.
- The department had one rostered Registered Nurse (child branch) during the 6pm – 2am shift. This was usually covered by bank or agency staff. This was not in line with the Royal College of Nursing (RCN) staffing guidelines, which states that '**all** registered nurses within a separate and dedicated children's emergency department must be a registered children's nurses'.
- However, the department had recently recruited to full establishment. At the time of our inspection, a proposal was out for consultation to have two registered nurses on duty at all times.
- At times when there was only one paediatric nurse their breaks would be covered by non-paediatric nurses. However, all staff were trained in paediatric immediate life support (PILS) and non-paediatric nurses received training on recognition of the unwell child and sepsis management to ensure they were able to treat children safely despite a shortage of paediatric nurses.
- The paediatric ED department was within the Women's and Children's Directorate. This meant that staffing oversight was maintained and reviewed daily by the paediatric matron and clinical lead for this service.
- ED would receive support from nurses from the children's ward at busy times, as staff could be flexed. The senior nurse on duty reviewed this daily or when required. However, staff movement was not officially recorded so would be difficult to evidence when and how long staff were moved in times of staffing shortages or additional requirements.
- There were two band seven nurses in the department who worked across the seven days and there was always a nurse on duty trained in European Paediatric Life Support (EPLS).
- We spoke with one agency nurse (registered nurse, not child branch) on shift at the time of our inspection. They had completed some elements of paediatric-specific training such as the triaging course. They demonstrated competence and awareness of triaging and treating children safely. They had gone through a trust and local induction and had also been proactive in undertaking the sepsis workshop to develop their skills and knowledge.

Medical staffing

- There was no specialist paediatric A&E consultant. The chief nurse and senior nurse of the department confirmed they were trying to recruit for this speciality but this was a recognised challenge.
- Between April 2015 and March 2016, the emergency department saw over 16,000 patients that were less than 17 years of age. The Royal College for Emergency Medicine (RCEM) recommends that in emergency departments seeing more than 16,000 children per year there should be at least one paediatric emergency consultant. The trust does have a consultant with an interest in paediatrics, but overall the trust did not meet this standard.
- There was a plan in place to increase paediatric registrars from 10 whole time equivalents (WTE) to 15, to allow a second paediatric registrar to be available 24 hours per day to support the ED Paediatric registrar.
- At the time of the inspection a second paediatric Registrar was available between the hours of 8.45pm to 9.15am Monday to Friday and 8.45am-9.15pm on a Saturday and Sunday. If the second shift was not covered this would be escalated to the consultant at handover.
- During the period 2 January 2017- 29 January 2017 14 shifts for the second paediatric register had remained unfilled, meaning that there would be no additional support to the ED registrar.
- At the time of the inspection a capacity review was being undertaken in line with the consultants' job plans to increase consultant cover on site until 8pm.

Major incident awareness and training

- Data on major incident training provided by the trust showed that 12 of the 14 nursing staff in the paediatric emergency department had completed this.

Urgent and emergency services

- We did not see the major incident procedure or what was included in the training. However, we did see a bespoke training programme for what to do in the event of a child abduction which included scenarios and a debrief exercise.
- We asked about major incident training for staff in the department and the senior nurse was not able to explain what the procedure was in the event of a major incident or the training arrangements for staff.

Are urgent and emergency services effective?
(for example, treatment is effective)

Are urgent and emergency services caring?

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Are urgent and emergency services well-led?

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Continue to recruit the specialist paediatric ED Consultant post to be in line with the Royal College for Emergency Medicine guidance.
- Continue to recruit to peadiatric Registrar vacancies to allow 24/7 additional support to the ED registrar.
- To ensure that the completion of the “safe to discharge” check is completed in all patient records by the medical teams.