The Regulation and Quality Improvement Authority

Unannounced Hospital Inspection Report
Royal Belfast Hospital for Sick Children

3 - 5 May 2017

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

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Abbreviations

ANTT	aseptic non touch technique
ED	Emergency Department
EMT	Executive Management Team
GMC	General Medical Council
HDU	High Dependency Unit
IMM	integrated medicine management
MDT	Multidisciplinary Team
NMC	Nursing and Midwifery Council
PEWS	Paediatric Early Warning Scores
PPE	personal protective equipment
QUIS	Quality of Interaction Schedule
RBHSC	Royal Belfast Hospital For Sick Children
RCA	Root cause analysis
RQIA	Regulation and Quality Improvement Authority
SKIN	surface, keep moving, increased moisture and nutrition and hydration
SSAU	short stay assessment unit
WTE	whole time equivalent

1.0 What We Look for

We assess if services are delivering, safe effective and compassionate care and if they are well led.

2.0 How We Inspect

To prioritise the areas we visit, we consider a range of factors including risk, quality and the context of the services.

These may include, for example, wards/departments:

- where previous inspections or our intelligence monitoring has flagged a concern or risk
- about which we have received a complaint, there has been a safeguarding alert or we have heard a disclosure from a whistle blower
- we have not inspected for a long period or have not previously inspected at all
- we have been made aware of areas of good practice
- a request has been made by the Department of Health, Health and Social Care Board or Public Health Agency
- which have been subject to media attention

We review a range of intelligence relevant to the service including: ward performance reports, healthcare associated infections rates, quality indicators, improvement plans and ward and trust wide governance documents.

Each hospital is assessed using an inspection framework. The approaches used include; observation of practice; focus groups with staff; discussion with patients and relatives and review of documentation. Records examined during the inspection include: nursing records, medical records, end of bed charts, staffing levels and rotas, performance reports and training records.

Acute Hospital Inspections will be led by Regulation and Quality Improvement Authority (RQIA) Medical Director and carried out by Health and Social Care Healthcare Team inspectors and other specialist RQIA inspectors. A senior Northern Ireland Medical and Dental Training Agency post-graduate trainee may be involved in our Acute Hospital Inspection Programme, thus providing medical representation and input to the team. RQIA is working in partnership with universities in Northern Ireland to provide opportunities for year three nursing students to participate, as observers.

Each inspection is supported by the use of peer reviewers (staff who are engaged in the day to day delivery of health and social care) and the use of lay assessors (service users and members of the public and who bring their own experience, fresh insight and a public focus to our inspections).

Guidance documentation related to the Acute Hospital Inspection Programme can be accessed on RQIA's website.
https://www.rqia.org.uk/guidance/guidance-for-service-providers/hospitals/

3.0 Profile of Service

The Royal Belfast Hospital for Sick Children (RBHSC) is one of four hospitals that make up the Belfast Health and Social Care Trust.

It is the only hospital in Northern Ireland dedicated specifically to the care of children. It has 107 beds and provides general hospital care for children living in Belfast, as well as providing most of the paediatric regional specialist services for children throughout Northern Ireland.

Responsible person:	**Position:**
Martin Dillon	Chief Executive Officer

4.0 Inspection Summary

An unannounced inspection was undertaken at the RBHSC over three days from Wednesday 3 May to Friday 5 May 2017. The following areas were inspected:

- Barbour Ward - orthopaedic/surgical and medical paediatric patients
- Emergency Department – including short stay assessment unit

Barbour Ward

We observed two dedicated deputy ward managers (band 6) sharing the managerial role on the ward, promoting the delivery of safe, effective and compassionate care.

Throughout the inspection, we observed that staff responded compassionately to the needs of the children and their relatives.

Ward staff work collaboratively to understand and meet the range and complexity of children's needs. We were told there was good multidisciplinary team (MDT) input and support on the ward. Nursing handovers and safety briefs are conducted at change of shift. We observed that these are informative, focused and structured. Staff were engaged in activities to monitor and assure quality of care delivered.

Staffing levels and skill mix are planned and reviewed. Some staff, however, reported that with reduced staff numbers particularly at night, they can sometimes find it challenging to be responsive to children's needs. We did not observe comfort or intentional care rounding taking place.

Junior doctors highlighted many areas of good practice on the ward including high quality, regular teaching and supervision, an emphasis on quality improvement and good team-working. They did however highlight concerns over staffing levels; too many children with complex care needs and information technology issues – it is a "paper heavy" ward.

We observed that the current ward layout had the potential to impact negatively on safety due to the mix of ages, conditions and acuity of the children receiving care on the ward. Safeguarding protocols and systems were in place to protect children from the risk of abuse. However, there was no safeguarding information on the ward for parents to easily read/access.

We observed the safe storage of medicines. Robust arrangements were in place for the management of controlled drugs.

Staff were familiar with critical medicines and their timely administration and demonstrated good use of communication boards to reinforce this information.

Staff reported that they can access the information they need to assess, plan and deliver care to patients in a timely way. Medical records were generally of a good standard and contained legible multidisciplinary notes. Improvements could be made in areas of a standardised surgical admission proforma, documentation of General Medical Council (GMC) number, details of amendments/deletions to patient records, estimated date of discharge and involvement of the child/relatives in decision making processes.

The ward meals service could be improved by designating a staff member to coordinate the service and reducing any unnecessary disruption to patients during meal-times. There was a good menu choice that included meals for specialised diets. Fluid balance charts were completed appropriately.

Pain assessment tools for children with differing communication abilities were freely available on the ward. We observed staff respond compassionately and in a timely way to children experiencing pain. The pain score was always documented on the Paediatric Early Warning Scores (PEWS) chart, however, on cross-reference with nursing notes, we noted that actions taken as a result of PEWS scores/triggers were not always documented. Staff were knowledgeable with regard to pressure ulcer and continence care.

On discussion with staff, it was notable that they were passionate about the care that children with palliative care needs and children at the end of life receive within the ward. The ward has side rooms (with ensuite facilities) which can be used for parents to facilitate overnight stay. A small play room with toys and sensory equipment is available within the ward for children to use.

Feedback from parents of children was mostly positive. Staff made them feel welcome and throughout their stay, their child was treated with dignity and respect. Some parents highlighted that they did not always know who to speak to about their child's care and they do not always receive up to date information. Most parents were satisfied with the care provided however, some commented that the ward needs more staff.

Some Comments from Parents and Relatives

"This unit is run to the utmost professionalism and efficiency. The standard of care is exceptional and nothing is ever too much trouble for the nurses."

"Could do with more staff."

"Ward is very good with the family."

"My son was to have an operation and I didn't know where canteen was."

"Monitor bleeped various times but no attendance of nurses."

"'No call bell."

Emergency Department

The Emergency Department (ED) was light bright and well maintained, with a spacious waiting area. Toys were available throughout the department for diversional play. Good leadership and governance systems were in place supporting the delivery of safe, effective and compassionate care. Staff reported that they were supported and felt valued by their senior departmental colleagues. Nursing staff reported that morale was good and that the multi-disciplinary team worked well together.

Throughout the inspection, we observed caring and compassionate staff deliver empathic and appropriate care and treatment to children and their parents. Staff showed excellent skills when dealing with distressed and crying children.

The short stay assessment unit (SSAU) for assessment, investigation and observation of children for a 24 hour period is located a distance away from the ED. It is staffed by nurses from ED, however, has no operational links to the ED. We were told that there are no clear medical or surgical lines of accountability for the unit. We noted that admissions to the unit were not always in line with the trust guidelines.

We were told nursing staff levels have not increased proportionally with the increase in patient numbers attending the ED. The need for additional staff has been discussed with senior trust staff over eighteen months ago and is still under review. The sister has one day protected for managerial duties.

Nursing staff turnover was low, there was no long term staff sickness and short term sickness levels were 1.6%. Training and supervision were up to date, and staff were encouraged to attend additional role-specific training.

Medical records in the ED were of a very good standard, with a comprehensive and well-organised 'flimsy' leading to comprehensive documentation. However, we noted omissions in relation to, GMC numbers, date and time amendments not countersigned, and pain assessments were incomplete.

Medicines were stored safely and securely. Robust arrangements were in place for the management of controlled drugs. There was no pharmacist dedicated to the ED at the time of inspection, therefore an integrated medicines management (IMM) service could not be implemented.

Sepsis six posters were observed throughout the department. ED medical staff have carried out a review of Sepsis six in relation to children taking into account anomalies such as potential over screening, over treating and non-aligned guidelines relating to children.

Children are encouraged to hydrate, relatives receive a leaflet in triage and lollies and cold water are available in the department.

We were informed that as a child's length of stay in ED was normally less than four hours meals are not routinely supplied.

Children appeared comfortable. Pressure relieving equipment is not routinely kept within the ED; however, staff told us that if required they can access a variety of pressure relieving equipment from the hospital wards.

We observed, and children and parents of children reported, that they were pain free. Parents advised that they were pleased with staff engagement and staff responded to children's needs for pain relief in a prompt timely manner.

To support end of life care, the ED has side rooms available and these can accommodate parents. Staff told us that if required children with palliative care needs are generally admitted directly to a ward in the Children's Hospital (rather than to/through ED), with a plan of care already agreed and in place prior to admission. The palliative care team is accessible; one of the ED staff nurses has experience of caring for patients with palliative care needs.

We observed a large number of patient records unfiled within the medical records filing area. A new electronic tracking is to be introduced in November 2017 to facilitate timely retrieval of records.

Some Comments from Parents and Relatives

Parents told us ED staff made them feel welcome, and throughout their stay, their child was treated with dignity and respect. They were satisfied with the care provided however some parents commented that there is not enough staff at busy times.

"Staff are very busy but there is an atmosphere of calm about the whole department. Sometimes the wait is much longer than today. The system seems to work fairly well. On busy occasions more staff would help. Staff are very friendly and efficient. Because we have been here before they know us so we always feel welcome."

Please note: this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with all relevant legislation, standards and best practice.

4.1 Inspection Outcome

Following the inspection, detailed feedback was provided to ward sisters and staff in Barbour Ward and the ED. This highlighted areas of good/best practice observed and also issues for improvement that could be addressed immediately. High level feedback which included areas of good practice and those for improvement was also provided to the trust Chief Executive and Executive Management Team (EMT).

As this was an initial inspection of these clinical areas (Barbour Ward and ED), there were no previous areas for improvement to be reviewed. Escalation procedures (as available on the RQIA website) were not required during this inspection.

www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/other-rqia-policies-and-procedures/rqia-escalation-policy-and-procedure/

Inspection Findings
Executive Management Team

5.0 Inspection Findings: Executive Management Team

Following this inspection, representatives from RQIA's EMT met with the trust's EMT to discuss overarching trust governance and management issues in relation to the RBHSC. Areas of good practice were acknowledged and clarification was sought regarding a number of areas identified during the inspection as requiring improvement.

Throughout the inspection, the senior team reported that we had observed caring and compassionate staff that endeavoured to provide quality care for children and their families. They acknowledged the number of quality improvement projects currently underway within the hospital, designed to assist in prioritising and improving patient care and the range of collaborative working arrangements in place to support the delivery of specialist care.

There was no clear nursing leadership within Barbour Ward; there has been no clinical nurse lead (band 7) on Barbour ward since December 2016 which has clearly impacted on the effective functioning of the ward. Challenges highlighted to RQIA from Barbour Ward staff related to the management of the complex mix of patient age, dependency and medical conditions which is exacerbated by the substandard ward environment. Nursing staffing levels and middle grade doctor staff shortages had impacted on overall workload, morale and reduced the ability of staff to avail of educational opportunities. Staff reported that a lack of visibility and engagement of senior management and executive teams had been very frustrating leaving them with a feeling that their problems were not being listened to. The hospital was described as having a disconnected leadership.

Documentation of evidence of key safety interventions such as the management of invasive devices and completion of paediatric early warning scores was not always present. Robust systems to assure that best practice is followed are not in place and should be developed going forward. We observed limited documented evidence of communication with parents and limited evidence of their involvement in planning and the delivery of their child's care.

We observed an ED with strong collaborative nursing and clinical leadership. Operational and governance arrangements which included staff supervision and appraisal were found to be effective. Morale was good with staff reporting that they felt supported and valued. Children and parents reported that their needs were attended to throughout their ED journey. The need for additional staff for the ED had been identified to senior management, to reflect the increasing demands on the service

It is not clear who is operationally responsible for the overall functioning of the short-stay assessment unit. Clear pathways for access, referral, admission to and discharge from to the unit were not in place.

The physical environment of the unit was not initially designed to address the needs of all infants, children and young people.

The trust told us that it was actively recruiting nurses, with a recruitment fair being held on the 6 May 2017. Normative staffing assessment has yet to be carried out in RBHSC. The availability of beds fluctuates in line with staff availability. Weekly care bundle audits are in place, however, development and roll out of peer and spot check audits still needs to be progressed. Participation in regional work to standardise paediatric documentation is progressing in conjunction with the Northern Ireland Practice and Education Council.

RQIA considered that all staff in the clinical areas visited are working hard given the limitations imposed by staffing levels and the environment. Following some discussion, the trust EMT recognises that further work is required to progress and improve those areas identified during the feedback.

Inspection Findings
Barbour Ward

6.0 Inspection Findings: Barbour Ward

Barbour ward is a 16 bedded paediatric regional surgical ward. The ward provides care for a very broad range of children in terms of age, dependency levels and complex/specialist service requirements - including children with orthopaedic, surgical, spinal and medical care needs. The ward also provides care for neonates and children requiring plastic surgery and specialist renal support, including children who are post-transplant.

6.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Areas of Good Practice

- We observed a high standard of hand hygiene practice being carried out by staff. Staff participate in peer audits of hand hygiene to provide assurance of implementation of best practice. The ward hand hygiene audit achieved 100 % in April 2017.

- Trigger tape was used to record when equipment had most recently been cleaned. We observed a high standard of environmental cleaning. Clinical hand washing sinks in the high dependency area were clean, accessible and located near to the point of care for staff to easily access and use (Picture 1).

Picture 1: Clinical hand washing sink

- The regional line labelling policy has been implemented in Barbour ward, to safeguard children by reducing the risk of 'wrong route administration'.

- The ward has a full time pharmacist who is responsible for medicines reconciliation during admission, stay and on discharge. Medicines were stored safely and securely on the ward. Robust arrangements were in place for the management of controlled drugs.

- Medicine kardexes were well completed. Good documentation of weight of each child and the allergy status was evident. In line with best practice, two members of staff were involved in preparing and administering intravenous (IV) medicines. We observed good use of communication boards to highlight time-critical medicines, for example, antibiotics and analgesics.

- Paediatric and General Practice medical trainees operating on a six month rota described a satisfactory ward and team induction process.

Areas for Improvement

- The ward has a sub optimal layout (one central area and three separate annexes). Children may be placed in an area not in sight of the main nurses' station on the ward. This has potential to impact negatively on safety and quality of care.

- We observed the delivery of care to neonates/infants mixed with the delivery of care to older children. This can result in added complexity for nursing and other professional staff delivering care on the ward. It is unusual to see this mixture of care, given the special medical and developmental needs of children of particular ages/age-groups.

- Many of the surgical/medical specialities catered for in Barbour ward are included in the category of augmented care. Barbour ward does not currently operate as an augmented care ward in terms of water management – there is no evidence of water flushing, water testing or records to provide assurance that opportunistic organisms such as *pseudomonas aeruginosa* are not present in the water system.

- One ward annex is currently being used to store equipment (Picture 2). We were advised and observed that the ward can at times be cluttered with children and family belongings. We were told that this can impact on the domestic staff and their ability to clean the ward.

Picture 2: Ward annex being used for the storage of excess equipment

- There is no call bell system in main High Dependency Unit (HDU) area of the ward. Parents and family members told us that where call bells were available and in use they were not always answered in a timely manner.

- Documentation relating to the insertion and management of devices such as nasogastric tubes and peripheral vascular catheters were not always completed as appropriate.

- We observed that disposable gloves and aprons were not always changed during aseptic non-touch technique (ANTT) procedures in line with best practice guidance.

- Gaps were noted in recording of cleaning of equipment on the resuscitation trolley. Similar findings were noted during a leadership walk round earlier this year (on 7 February 2017). The temporary closure on the sharps box was not deployed.

- PEWS charts reviewed were appropriately completed. However, on cross reference with nursing records, we noted that actions taken as a result of PEWS scores/triggers were not always documented.

- Hospital reports on CDI and MRSA rates were not cascaded to the two deputy ward managers, who were unaware of the date and details of the last root cause analysis (RCA) for an infection attributed to the ward within the last year.

- Foundation Doctors rotating on a four-monthly basis consider their ward and team induction process to be suboptimal. The doctors advised us that they required focused training in paediatric life support, paediatric fluid prescribing, management of paediatric emergencies and paediatric drug calculations.

- There was no evidence of an effective system to monitor antimicrobial prescribing and stewardship. The maximum and minimum temperatures for the ward refrigerator were not being monitored and when checked during the inspection were outside of the required range.

Actions for Improvement

1. **The trust should review and improve the layout/use of space available on Barbour Ward, including provision of a call bell system in the HDU area, to ensure all children can be observed safely.**

2. **The trust should ensure actions are taken to implement a water testing regime on the ward in line with best practice guidance for augmented care areas.**

3. **Excess equipment should be removed from the ward to facilitate effective environmental cleaning. Adherence to equipment cleaning schedules and recording and monitoring of the medication refrigerator temperature range should be routinely audited.**

4. **Best practice in the management of invasive devices and in the calculation, documentation and escalation of paediatric early warning scores should be regularly assured.**

5. **All staff should be reminded to wear personal protective equipment (PPE) in line with aseptic non-touch technique guidelines. Routine audits of staff practice should ensure adherence to best practice guidelines.**

6. **Information on hospital and ward infection rates and RCA should be cascaded through senior ward staff for information and to support learning for all ward staff.**

7. **The trust should review and improve the Foundation Doctors induction programme to ensure training is appropriate to their role and clinical requirements.**

8. **The trust should review and implement an effective system to monitor antimicrobial prescribing and stewardship on the ward.**

6.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome.

Areas of Good Practice

- Medical staff entries in children's notes were generally structured and legible. There was evidence of multidisciplinary and multi-speciality involvement in care delivery in several of the notes.

- The children's hospital has an established catering group which is currently reviewing menus and the provision of food for children and services for parents out of hours. Fluid balance charts reviewed were well completed.

- Pain assessment tools for children with different communication ability are available on the ward for staff, to support accurate assessment of pain. We observed, and children reported that they were pain free. Parents told us that staff responded to children's needs in a timely manner. Staff have access to a specialist pain nurse and doctor for advice.

- The Glamorgan scale (2012) paediatric pressure ulcer risk assessment is part of the ward's routine nursing admission assessment for children. Children who are assessed and deemed 'at risk' with a score of ten or more are commenced on a SKIN bundle (surface, keep moving, increased moisture, nutrition and hydration).

- Children appeared comfortable. Staff advised that they can access a variety of pressure relieving equipment including gel supports, profiling beds and bed cradles. Occupational therapists regularly visit the ward to access children and provide them with additional equipment as required. Mattress audits are carried out, with a mattress replacement programme in place as required.

- Staff told us that nurse specialists including tissue viability nurse service and stoma/incontinence nurses are easily accessible and provide a responsive service to the ward. Stoma and incontinence aids are available within the ward.

Areas for Improvement

- Of the six nursing records reviewed, we observed that only one set of records contained a documented care plan. Not all nursing and/or care risk assessments were comprehensively completed.

There was limited documented evidence of communication with parents and their involvement in planning and delivery of care.

- Not all documentation reviewed was completed in line with Nursing and Midwifery Council (NMC) guidance, for example, clear signature, time recorded and deletions signed.

- Nursing documentation audits are not routinely carried out on the ward. We were told that no audit tool has been developed to support audit of nursing records. Nursing staff informed us that they do not find the current nursing booklet easy to use.

- Of the six medical records reviewed, loose sheets were identified in many of the notes and we saw no evidence of a standardised surgical admission of discharge summary proforma. GMC number, details for amendments/deletions in notes and documentation of involvement of the child/relatives in the decision making process were not fully recorded.

- Protected meal times were not observed (at breakfast a ward round was carried out; and a designated person was not always in charge during the meal service (supervising and co-ordinating). We observed meals dispensed to children on plates, trays were not used, and on occasion, insufficient cutlery was provided.

- We identified that staff did not always use food charts or stool charts to accurately monitor oral intake or episodes of diarrhoea. For one child who was unable to verbalise pain, staff did not use an available alternative method to assess pain.

- Staff can access the Health and Social Care Northern Ireland Wound Formulary (April 2011) online. However, there was no visual aid/poster readily available to assist nursing staff in the classification and management of pressure ulcers if required.

Actions for Improvement

9. **The trust should audit completion of medical and nursing records to ensure adherence to best practice in line with the GMC and NMC guidance.**

10. **The ward should review operation of its meal service and ensure a robust system is implemented with appropriate supervision and co-ordination in place.**

11. **Ward staff should be updated the assessment of pain for those children unable to verbalise pain. Visual aid/posters on the classification of pressure ulcers should be readily available for staff.**

6.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Areas of Good Practice

Picture 3: Play room in Barbour Ward

- A small playroom with toys and sensory equipment is available within the ward for children to use (Picture 3).
- We observed staff on the ward providing compassionate care. Interaction between staff, children and families was encouraging and empathetic. Staff can access interpreting services if required.
- Junior doctors highlighted good MDT working and communication. They described an 'open culture' and indicated they felt comfortable in raising concerns. Junior doctors also described an emphasis on improving care, with encouragement and support for quality improvement projects.
- We saw evidence of good mechanisms for communication of information to staff by way of email, safety briefings and handovers. Compliments in relation to care provided were shared with all staff on notice boards.
- Information leaflets and access to support groups are available for parents before and after bereavement. The trust has a bereavement coordinator to support parents. We were told that following consultation, information available for parents was recently reviewed to ensure it encompassed all age groups potentially receiving care on the ward. Chaplaincy services are available.
- To support end of life care, the ward has side rooms (with ensuite facilities) which can be used for parents to facilitate overnight stay.

Dining facilities are available during the day, with staff providing tea and toast out of hours. Car parking vouchers are available for parents.

- Staff told us that when required the trust palliative care team is responsive and supportive. Off-site child and parent accommodation is available for those receiving palliative care.

- Staff told us that they are taking part in a regional initiative with the Northern Ireland Hospice to develop an end of life policy.

Areas for Improvement

- A call bell system is not in place in the HDU area immediately opposite the nurses' station. Staff told us that this was not in place as parents/relatives were always present; however, we observed that for some children in this area parents/relatives were not always in attendance.

- On occasion, bedside curtains were not always fully closed to maintain privacy, for example, when changing children's clothing. The central/main ward area can be noisy; the ward operates a policy of two people (parents/relatives) per bed, we observed that this is not always adhered to.

- The current ward layout does not support the provision of dedicated areas for privacy and confidentiality for parents/relatives. There is no quiet room for parents to use for private/confidential conversations. These conversations are frequently undertaken at the bedside or in the multidisciplinary room, which requires redecoration.

- We did not see evidence of regular parental involvement in MDT meetings, to plan and agree the continuing care of children who have prolonged admissions to/episodes of care on the ward.

- The play therapist covers several clinical areas and is not dedicated to the ward. This can delay access to the play therapist for children receiving care on the ward. The play therapist affiliated to the ward is currently on maternity leave and staff informed us that they are not aware of any plans to cover this expected period of leave.

- We observed that staff did not always speak discreetly when engaging with children and relatives about their child's medical condition. We noted evidence of occasionally challenging communication between parents and medical staff relating to the explanation and implementation of clinical care and related interventions.

- We noted that on occasion, staff did not identify the emotional needs of a parent (of a child having surgery) and consequently did not put in place systems to reassure and support the parent.

We did not see evidence of signposting of parents towards advocacy services. There was no evidence of child comfort rounds on the ward.

- There was no easily accessible information (in various formats or languages) on the ward. Nursing staff told us they do not have access to cards to assist communication; these are however available to ward teachers.

- An integrated care pathway or guidance relating to end of life care was not available for staff to access/use.

Actions for Improvement

12. **Children's privacy and dignity should be maintained at all times. Private conversations should be carried out in an appropriate environment to ensure confidentiality. Ward staff should support family members to implement the two people per bed policy.**

13. **Parents/guardians and children (where appropriate) should be actively involved in decisions about care. This should be fully documented within care records.**

14. **Children receiving care on the ward should have timely access to a play therapist.**

15. **Staff should be supported to take account of the emotional needs of parents/guardians, which should be identified and addressed as appropriate.**

16. **Ward and/or service related information should be available for staff and parents in various formats to include; communication cards, advocacy services, guidelines, policies.**

6.4 Is the Area Well Led?

The clinical area is managed in and organised in a way that patients and staff feel safe, secure and supported.

Areas of Good Practice

- We observed all grades and disciplines of staff working well together as a team, providing compassionate nursing care and support to children, patients and relatives.

- Nursing staff advised us that the ward deputy managers are supportive, senior children's hospital management visit and engage with ward staff on a weekly basis.

- We observed the deputy ward managers actively involved in supporting staff, listening to their needs and arranging educational study days in an effort to sufficiently equip staff to undertake their role.

- Staff told us that they are supported in their role through meaningful and timely supervision and appraisal; staff talked positively about these processes.

- Staff told us about quality improvement projects currently underway in the ward, which will assist in prioritising and improving patient care, for example, the Barbour Improvement Group (BIG) and "what matters to me" to promote staff feedback and encourage suggestions for improvement (Picture 4).

Picture 4: Barbour Improvement Group (BIG) whiteboard, staff feedback and suggestions

- We were informed that no staff member has been off on sick leave for more than six weeks.

  When required, staff sickness is managed in line with trust policy and supported with advice from the trust's human resources and occupational health departments.

- We observed the morning nursing staff handover. Delivery of the handover was focused, structured and well led. It was evident from observation and from the nursing handover that all staff were familiar with the characteristics of the longer stay children, including their mannerisms and their usual patterns of behaviour.

- Staff have received mandatory and role-specific training to enable them to carry out their roles effectively.

Staff were aware of the process to report incidents, including serious adverse incidents and near misses, and were kept up-to-date with learning from incidents and complaints.

- Information posters are on display within the ward to direct staff on how to access specialist safeguarding advice. There is no unauthorised access to the clinical area. The ward is accessed via buzzer entry system only.

- Clinical staff who are interested in quality-improvement, are engaged in wider educational and specialist networks and have leadership roles in these areas. Learning and knowledge form their work will influence improvement in the care delivered to children within the ward.

- There are a number of quality improvement projects currently underway within the hospital and ward designed to assist in prioritising and improving patient care. For example; the pharmacy service is introducing electronic prescriptions to speed up child discharge.

- There is a range of collaborative working arrangements in place to support the delivery of specialist care to children including:
  - in-reach initiatives with quaternary specialist services in the United Kingdom, for example metabolic, endocrine and urological care
  - out-reach initiatives to other level two hospitals in Northern Ireland, such as Project ECHO and specialist networks in diabetes, epilepsy and other services
  - multidisciplinary staff plan to actively participate in a workshop supporting the establishment of a local Paediatric Network, to improve and standardise care delivered to children across Northern Ireland

- We noted that staff received many compliments from parents/guardians and relatives by way of cards/letters and acknowledgements for care delivered.

Areas for Improvement

- There has been no clinical nurse lead (band 7) on Barbour ward since December 2016. We were told that the deputy ward managers were given minimal protected time and routinely complete administrative work at home. They juggle care delivery and ward management as well as the supervision of junior staff. There was no clear identification of which nurse was in charge of the ward overnight.

- The deputy ward managers have no access to staff human resources payroll travel and subsistence (HRPTS) to facilitate their managerial role and they are not linked to broader governance structures in the hospital.

- The ward recently lost six whole time equivalent (WTE) senior nursing staff, currently has four WTE nursing vacancies and has several junior nursing staff in position. We were told that the ongoing staffing issues can create difficulties with the staff off duty rota and in achieving the correct skill mix per shift. The complex case mix and dependency levels, the absence of protected supervisory governance and loss of nursing expertise are of concern.

- Nursing staff told us that morale was varied. Morale can be linked to the ward workload, complexity of patients, staffing levels and staff skill mix. Trust management and executive team were reported as less frequently visible on the ward.

- Senior medical staff reported their frustration regarding challenges currently experienced in relation to Barbour Ward (child mix, capacity/workload demands, nursing staff shortages, paper-based systems). They highlighted challenges relating to the lack of middle grade doctors and a need to ensure doctors completing specialist training are retained within the current service to support sustainability.

- Junior doctors report their perception of inadequate staffing levels, both nursing and doctors in training. This impacts greatly on the workload of all professions on the ward, and can frequently lead to delays in important aspects of patient care such as procedures or investigations performed. Workloads were also thought to affect participation in teaching and education activities, with a majority of junior doctors' time on the ward dedicated to service provision.

- Junior doctors felt supported in raising concerns on an informal basis via their supervisors. They did not see the value in formalising concerns through incident reports (IR1 forms) or other processes and described several instances of being discouraged by supervisors from completing such forms. They felt there should be an updated and more relevant system for reporting concerns and learning from 'near misses'.

- Staff advised that due to staffing levels and the lack of available beds, they are unable to implement regional guidelines, which advise that children up to the age of 16 years should be cared for within children's wards.

- Staff working in support services, administration and medical records told us they were concerned that term time working patterns could lead to staff shortages and impact on their ability to deliver a service. There is no ward portering service.

- Staff told us that current IT equipment including computers and the ward photocopier were dated and prone to breaking down. We observed that quality improvement work, reports and handovers currently relies heavily on the completion of paper rather than computerised systems. This is time consuming for staff.

- There was no safeguarding information for parents to easily access on the ward. Clerical staff had not received training on child protection. This would be considered best practice as training commensurate with their role.

- On spot checking of access to policies, we identified that staff were unable to access a policy on self – administration of medication and could only locate a food, fluids and nutritional policy related to adult care.

Actions for Improvement

17. **A senior nurse manager (band 7) should be appointed to Barbour ward with immediate effect. Protected time should be allocated to facilitate effective supervision of staff and management of the ward.**

18. **The trust should review and improve the nursing and medical staffing levels within the ward in order to improve staff morale and address challenges identified by staff.**

19. **The trust should ensure appropriate completion and submission of incident reports (IR1) to identify areas of concern and ensure learning from near misses.**

20. **The trust should work with key stakeholders to address issues that prevent the implementation of regional guidelines relating to age-appropriate care (i.e. provision of care to children up to the age of 16 years).**

21. **The trust should support ward staff to explore and adapt paper free systems (such as electronic healthcare software systems) to reduce time spent on completion and management of paper documentation**.

22. **All ward staff should receive safeguarding training commensurate with their role.**

6.5 QUIS/Questionnaires/Observations

During inspections, the views and experiences of patients and service users are central to helping the inspection team build up a picture of the care experienced in the areas inspected.

We use questionnaires to allow patients and relatives to share their views and experiences.

The inspection team also observed the communication and interactions between staff and patients and staff and visitors. This is carried out using the Quality of Interaction Schedule (QUIS)[1].

Findings are presented from a composite perspective, combining the patient and relative perceptions.

Parents Questionnaires

Parents told us that staff made them feel welcome and throughout their stay, their relative was treated with dignity and respect. Some parents highlighted that they did not always know who to speak to about their child's care and they do not always receive up to date information. Most parents were satisfied with the care provided however some commented that the ward requires more staff.

Comments

"This unit is run to the utmost professionalism and efficiency. The standard of care is exceptional and nothing is ever too much trouble for the nurses."

"Could do with more staff."

"More activities required for each child's ability."

"Better more comfortable roll out beds for parents staying overnight."

"More cup sizes needed for mums breastfeeding."

"No call bell."

"I haven't been shown to the shower or toilet."

"My son was to have an operation and I didn't know where canteen was."
"Monitor bleeped various times but no attendance of nurses."

"Ward is very good with the family."

Observations

Inspectors and peer reviewers undertook a number of periods of observation using QUIS observation tool to record interactions between staff, patients and visitors. 27 observations were carried out over four observation sessions. Each session lasted approximately 20 minutes.

[1] https://www.rqia.org.uk/guidance/guidance-for-service-providers/hospitals/

We observed the majority of the interactions to be positive. Staff actively engaged with children and parents and provided encouragement and support during care tasks. Staff provided clear explanations of care tailored to the needs of children and parents. Throughout the inspection, we however, observed some gaps in maintaining the dignity and privacy of children. Staff should ensure that when providing care privacy screens are fully drawn and staff speak discreetly when discussing confidential information.

Inspection Findings
Emergency Department

7.0 Inspection Findings: Emergency Department

The Emergency Department (ED), open 24 hours per day, is the only dedicated Children's ED in Northern Ireland. The department has a large waiting area, a triage room, central clinical work station, six cubicles, a two bed observation room, treatment and review rooms, x-ray and plaster room and a two bed resuscitation room.

In addition, an SSAU is located some distance away from the main ED. Opened in 2014, the SSAU has capacity to care for eight children, with accommodation comprising of one en-suite side room, one four bedded bay and one three bedded bay. Infants, children and young people with acute illness, injury or other urgent referrals from clinicians can be assessed, investigated and observed or treated within an optimum period of care of less than 24 hours in the unit. The SSAU is staffed by nurses from ED, however, has no operational links to ED.

7.1 Is Care Safe?

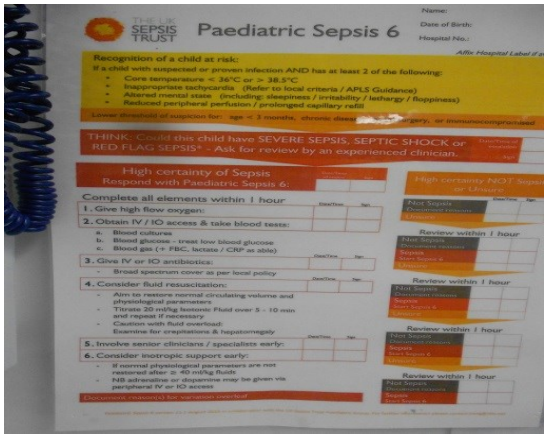
Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

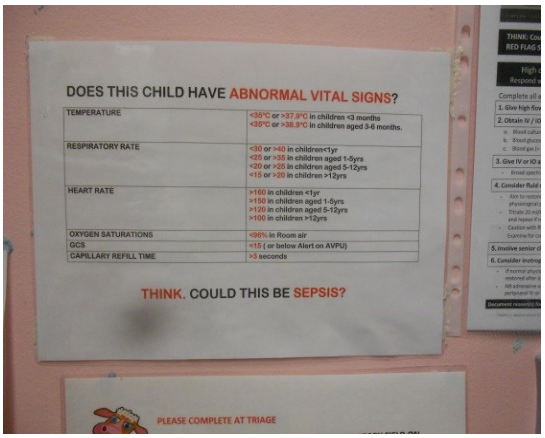
Areas of Good Practice

- Staff were complying with the best practice letter *Identifying an acutely unwell child on arrival in the Emergency Department',* the standard that all children aged 5 years and under are visually assessed by a registered practitioner immediately on arrival in emergency care settings (Public Health Agency, October 2016).

- A consultant carried out a review of the previous day's flimsies and x-ray reports. There is a process whereby staff contact either the parents or General Practitioner of children who leave the ED without completing their treatment or being formally discharged.

- The Sepsis 6 initiative has been introduced within the ED to recognise the early signs of sepsis in children and provide treatment it in a time critical manner (Pictures 5 and 6). Sepsis six posters were observed throughout the department. Medical staff have carried out a quality review of the review of Sepsis six in relation to children taking into account anomalies such as potential over screening, over treating and non-aligned guidelines relating to children. Early warning systems now include a prompt "could this be sepsis six". We were informed that this work has been shared with another trust.





Pictures 5 and 6: Paediatric Sepsis Six Posters

- A simulation exercise was held on 10 March 2017, to test the department's response to an incident of massive haemorrhage in children. The purpose was to highlight patient safety issues in a learning environment.

- The ED is in the initial stages of implementing the regional line labelling policy, to safeguard children by reducing the risk of 'wrong route administration'.

- Medicines were stored safely and securely. Robust arrangements were in place for the management of controlled drugs. Patient kardexes examined were well maintained. There was good documentation of each child's weight and allergy status and a good use of communication boards to highlight time-critical medicines for example antibiotics and analgesics.

- A range of hand hygiene consumables were available. Alcohol gel, personal protective equipment dispensers and clinical hand wash sinks located throughout the department were clean; some were in need of repair. Patient equipment cleaning schedules were in place, completed twice daily and audited to provide assurance.

- ED cubicles were spacious, clean and well equipped. Single rooms were available for patents that required isolation. There was good staff compliance with hand hygiene and ANTT practices.

Areas for Improvement

- The SSAU has capacity to care for eight children (Picture 7). The unit, situated away from the main ED, is small with little natural light or ventilation. The unit has one shared toilet and no shower or wash facilities for children or relatives, and no beverage point. The small and cramped layout of the SSAU does not support patient privacy.

Picture 7: SSAU - four bedded bay

- The ED has only one room dedicated for triage; staff reported that this is not sufficient particularly if two or three children need to be triaged concurrently. We observed that staff use the relatives' room to carry out care when the ED is busy. The layout and design of the ED is not a conducive environment for promoting patient privacy.

- In ED while we observed good communication between medical and nursing staff. To assist patient flow a joint medical and nurse board round had process had just commenced in the department.

- On reviewing care documentation we observed some omissions in relation to the insertion and maintenance of a peripheral vascular catheter. The triangulation between PEWS charts and nursing records to record action taken as a result of PEWS scores and triggers was not evident.

- In the SSAU we identified that pain assessment was not documented on all PEWS charts or recorded on the patient admission flimsy.

- Staff reported that they had insufficient equipment. Equipment is currently shared between the areas within ED which can sometimes leave staff short of observation monitors. There was also a shortage of portering chairs.

- There is currently no pharmacist dedicated to the ED, therefore an IMM service cannot be implemented. Nurses are currently undertaking tasks which could be completed by a pharmacy technician, for example, ordering and date checking drugs, sorting and storage of drug supplies.

- We found no evidence of a system to monitor antimicrobial prescribing and/or stewardship.

- With the exception of the main nurses' clinical work station, there is no private area to prepare medication (Picture 8).

Picture 8: Central clinical work station

Actions for Improvement

1. **The trust should review and improve the location of and facilities provided within the SSAU.**

2. **The trust should consider a second suitably equipped room which could be used for children's triage during times of crowding and increased attendance to ED.**

3. **Best practice in the management of invasive devices and in the calculation, documentation and escalation of paediatric early warning scores should be regularly assured.**

4. **The ED should ensure staff have access to equipment in order to carry out their role. Additional observations monitors should be purchased.**

5. **A dedicated pharmacy service/input should be agreed for the ED to facilitate an effective integrated medicines management service and to facilitate appropriate antimicrobial stewardship.**

7.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome.

Areas of Good Practice

- Medical records in the ED were of a very good standard, with a comprehensive and well-organised 'flimsy' in use.

This flimsy included a patient information leaflet section which was completed and countersigned by parents/carers when they were provided with information on discharge. There was also evidence of 'safety netting' on discharge, with advice to parents well documented. There were several proformas present in children's notes, including intranasal diamorphine and infection prevention and control sheets which were also completed well.

- Children were encouraged to hydrate, relatives received a leaflet in triage, and lollies and cold water were available in the department.

Areas for Improvement

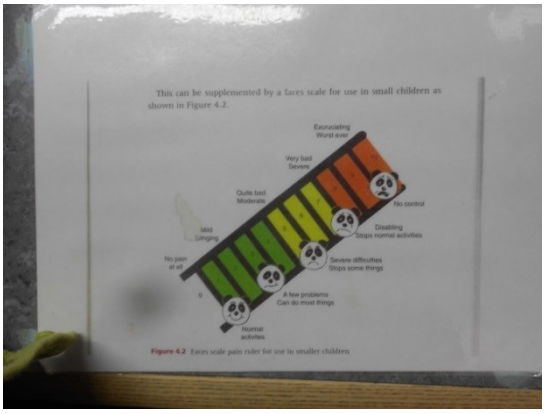
- The nursing documentation reviewed in the SSAU was not always completed in line with NMC guidance. We found no evidence that audits of nursing documentation are undertaken.

- There was limited documented evidence of communication with parents in relation to the delivery of care.

- Of the flimsies reviewed, we noted omissions in relation to GMC numbers, date and time amendments not countersigned, and incomplete pain assessments.

- There are no out of hour's arrangement for children or parents once the café facilities and catering department close.

- There was only one pictorial guide for pain assessment available in the ED; this was in the triage room (Picture 9). Additional guides should be available for staff to ensure the continued appropriate assessment of ongoing pain.



Picture 9: Pictorial guide for pain assessment

- In the SSAU, we noted inconsistencies in recording of fluids between children's fluid balance chart and their care plan.

Actions for Improvement

6. **Robust assurance/audits of the completion of nursing and medical records to ensure adherence to best practice in line with the GMC and NMC guidance should be in place.**

7. **Out of hours catering facilities for children and relatives should be reviewed.**

8. **Assurance audits should be carried out to ensure fluid balance charts are appropriately completed in line with best practice. Additional pictorial pain guides should be made available across the ED and SSAU for staff to reference.**

7.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Areas of Good Practice

- We observed staff in the ED providing care; there was good appropriate interaction between children and families. Staff displayed sensitivity and encouragement and gave good explanations to children and parents.

- One nurse within the ED had knowledge of Makaton (the use of signs and symbols to help communication).

- The ED has a dedicated room for use by families who have suffered bereavement.

- Staff are taking part in regional work with the Northern Ireland Hospice to develop an end of life policy.

Areas for Improvement

- There was no evidence of routine children's comfort rounds.

- The ED and SSAU have access to a play therapist; however, staff advised us that this service is part time and insufficient to meet the children's needs.

- Relatives and staff highlighted that the absence of a cash machine, ATM, in the children's hospital can be challenging, particularly at times of concern/worry (for relatives) and heavy workload (for staff).

- A small sign is present in the waiting area with details of the National Society for the Prevention of Cruelty to Children; however, there was no safeguarding information in the ED for children or parents to easily access.

- Staff did not always introduce themselves and were not aware of the "hello my name is" initiative.

- The ED has a bereavement box; however information within this relates only to neonates or babies. There is no information suitable for parents or family members of children of all ages potentially receiving care within the ED. Staff could not access the trust online care pathway for end of life care, some staff were not aware that the trust has a bereavement co-ordinator to help support parents and family members.

Actions for Improvement

9. **Children receiving care in the ED should have timely access to a play therapist.**

10. **The feasibility of installing a cash dispensing machine in the Children's Hospital should be explored.**

11. **The ED should ensure safeguarding information is readily available for children and parents.**

12. **Staff should have an opportunity to become familiar with and introduce the 'hello my name is campaign' in their clinical areas.**

13. **Information on bereavement should be available for children of all ages who may attend ED. All staff should be aware of how to access the trust care pathway and/or bereavement co-ordinator.**

7.4 Is the Area Well Led?

The clinical area is managed in and organised in a way that patients and staff feel safe, secure and supported.

Areas of Good Practice

- We saw compassionate, empathetic and appropriate care delivered to children.

- The leadership and governance systems within the ED promoted the delivery of safe, effective and compassionate care.

We observed that senior ED medical and nursing staff were visible, approachable and leading effectively. Nursing staff reported that morale was good and that all members of the multi-disciplinary team work well together. Staff indicated they felt supported by direct line management and were able to raise concerns.

- Staff turnover was low, two staff had left in the past year, 2.5 WTE band 5 positions were in the process of being filled. There was no long time sickness and short term sickness was 1.6%. Nursing staff training, appraisal and supervision were up to date. There are 17 nurses trained as staff mentors. One of the staff has been put forward for a national 'mentor of the year' award.

- Staff identified learning from complaints and safety incident reports (IR1s) and following serious event audits. The quality manager reviews all IR1s weekly and trends and learning is fed back to staff via the daily safety briefing. There is a process in place that facilitates "lessons learned" training following a serious event.

- There is a system of link persons to support the ED for example infection prevention and control, advanced paediatric life support instructors, ANTT, tissue viability.

- Nursing and medical staff displayed good knowledge of local safeguarding arrangements.

- There are a number of quality improvement projects currently underway within the hospital and ED, which will assist in prioritising and improving patient care. For example, the social work team with input from external services, are creating a pathway for self-harm. This is to improve and ensure the standardisation of care for all children presenting with self-harm. The ED has an identified safety goal of the week (Picture 10).

Picture 10: Safety Goal of the week poster

Areas for Improvement

- The current ED nursing staff compliment meets the commissioning levels which were set out following the department's upgrade in 1999. While nursing staff levels have remained static, the number of ED attendances has increased over recent years. The current nurse staffing complement would benefit from review, to establish if additional input and/or skill mix is required in the context of current ED activity.

- The SSAU was established to care for children whose expected in-patient stay is less than 24 hours. The unit is staffed by nurses from ED but has no links to ED either through operational responsibility or physical location. It is not clear who is operationally responsible from a medical/surgical perspective for the overall functioning of the unit. Currently the unit is not functioning as an SSAU - for example we noted the placement of a child with complex needs into the SSAU, rather than to a ward, at the same time we noted the admission of a child with a pyrexia to a ward and not the SSAU, and their subsequent discharge within seven hours of admission.

- Junior doctors described rota cover on the first tier rota as satisfactory; however, we noted extensive gaps on the middle tier (registrar) rota. Currently, 0.75 WTE doctors are staffing a 6 person rota at the middle tier level, within the next month there may be no doctors on this middle-tier rota. Junior doctors reported that rota gaps are not currently impacting on patient care, as ED Consultants are taking on increased duties/workloads; however, this approach is very unlikely to be sustainable going forward.

- From 9.00am to 12.00 midnight consultants are present in the ED; however, for the remaining overnight period (12.00 midnight to 9.00am) only one first tier doctor is present. Junior medical staff indicated that at times overnight cover can be insufficient due to the volume and/or complexity of children presenting. Junior medical staff in the ED reported they were supported by the medical staff on the hospital wards; however, they are reluctant to regularly rely on this support as the ward-based medical staff were also very busy overnight.

- To date, medical handover in the ED has been on an informal basis (from one junior doctor to another) and there has been no medical involvement with the nursing handover or safety briefing. Junior medical staff expressed an interest in participating in multidisciplinary ED updates and safety briefings. A new ED safety briefing was introduced on 2 May 2017; this briefing is medically led and involves the MDT (medical, nursing and patient flow).

- We observed a large number of unfiled patient records within the medical records area.

A new electronic tracking system is to be introduced in November 2017; however we noted a considerable current backlog in this area (Picture 11). Night reception staff expressed concerns in retrieving child's medical records.

Picture 11: Patients records for filing

- There is no porter system in place in the children's hospital; nursing staff are required to cover this role. This puts additional pressure on nursing staff and can leave the ED short staffed for periods of time.

- We found no evidence that data and/or intelligence relating to patient experience is captured or used to inform service delivery and improvement.

- Social work staff reported that the Trust safeguarding referral process was in place and working well. A plan is in place in ED to re-designate the initial responsibility for safeguarding referral from the specialist safeguarding nurse to ED nurses. Minutes of the ED Interface Safeguarding meeting evidenced that this change in process is in line with other organisations. However, ED nurses were concerned that this change has the potential to impact on safeguarding processes and the follow up of regional referrals outside of the trust.

- There was no up to date guidance in place to inform staff of the use of PEWS and ensure its appropriate and standardised use.

Actions for Improvement

14. **The trust should continue to actively recruit medical and nursing staff at the appropriate grade to ensure that patient care and safety is not compromised due to staffing levels. There should be sufficient portering service available to support the ED.**

15. **The trust should agree an operational model and governance arrangements for the SSAU, this should include clarity regarding which patients should be admitted, for how long and a clear outline of roles and responsibilities in relation to operation of the unit as an SSAU.**

16. **Consideration should be given to the introduction of a formal medical handover in the ED.**

17. **The trust should ensure immediate interim measures are in place to ensure the patient's files are stored to enable timely retrieval pending the introduction of the new electronic system in November.**

18. **Information relating to child's and relative's experience should be captured and used to inform service delivery and improvement.**

19. **The trust should ensure a change to the safeguarding process does not impact on safeguarding and the follow up of regional referrals outside of the trust.**

20. **Guidance on PEWS should be updated to ensure a standardised approach by all staff in carrying out and completing PEWS.**

7.5 QUIS/Questionnaires/Observations

During inspections, the views and experiences of patients and service users are central to helping the inspection team build up a picture of the care experienced in the areas inspected.

We use questionnaires to allow patients and relatives to share their views and experiences. The inspection team also observed the communication and interactions between staff and patients and staff and visitors. This is carried out using the QUIS.

Findings are presented from a composite perspective, combining the patient and relative perceptions.

Parents Questionnaires

Parents told us ED staff made them feel welcome, and throughout their stay, their child was treated with dignity and respect. They were satisfied with the care provided however some parents commented that there is not enough staff at busy times.

Comments

"Everything has gone very smoothly and quickly this morning. My daughter hurt her arm on Monday but we held off until this morning. The staff have been very helpful. No complaints."

"The staff have been very efficient and the department appears to be working well this morning."

"Happy with the care received. Haven't had to wait too long. Kept informed at all stages."

"Staff are excellent, good at communicating and she knows what is happening and what the next stage will be. Very satisfied."

"Staff are very busy but there is an atmosphere of calm about the whole department. Sometimes the wait is much longer than today. The system seems to work fairly well. On busy occasions more staff would help. Staff are very friendly and efficient. Because we have been here before they know us so we always feel welcome."

"Staff have been lovely and are good at keeping the family informed about what is happening. No complaints."

"No complaints. Seen fairly quickly and efficiently. All grades of staff have been excellent."

"Very busy, not enough staff on occasions."

"Staff have been brilliant."

Observations

Inspectors and peer reviewers undertook a number of periods of observation using QUIS observation tool to record interactions between staff, patients and visitors. 25 observations were carried out over four observation sessions. Each session lasted approximately 20 minutes.

Staff interaction with children and parents was polite and compassionate, although staff should ensure that they introduce themselves during initial interaction. Staff responded to requests quickly giving clear explanations on the care to be delivered. We observed that children's privacy and dignity of was maintained at all times.

Inspection Findings
Focus Groups

8.0 Inspection Findings: Focus Groups

During the inspection a series of focus groups and/or interviews were held with the following groups of staff who were aligned to the clinical areas inspected:

- Nurses and healthcare assistants
- Allied Health Professionals
- Support Staff including porters, administration, catering, security
- Junior and Senior Medical Staff
- Senior Managers
- Executive Management Team

We found all staff to be open, honest and willing to discuss good practice and areas for improvement within their area of work. This confirmed findings outlined in the report for Barbour Ward and the ED.

All groups of staff told us they felt supported by their direct line manager to carry out their role. However, staff also told us that trust senior management including the executive team were not routinely visible within their clinical/ward areas. We were told that all areas were very busy and could be challenging to work in. All groups of staff told us this was particularly evident in Barbour ward, the ED and SSAU as a result of increased workload, reduced staffing numbers, staff skill mix, number and acuity of patients and environmental constraints. These issues had been raised with trust management; however we were told by staff they felt that no one was listening.

Barbour Ward staff reported that their senior ward staff are supportive; however there is no clinical nurse lead (band 7) to carry out the ward managerial role. Nursing staff vacancies, staff skill mix, complexity of patients, ward configuration and a reduced number of experienced senior nursing staff were areas of concern. Some staff reported varying levels of morale and did not feel supported or listened to by trust management and the executive team. Junior medical reported that nursing and medical staffing levels were considered to be inadequate. Senior medical staff reported frustrations in relation to ward configuration and workload demands.

In the ED, staff reported that team work between nursing and medical staff was good. Senior ED nursing and clinical staff were supportive. However, medical cover overnight and the reduced number of nursing staff can be insufficient to deal with the volume and/or complexity of children presenting. There is no dedicated ED pharmacist; therefore nurses carry out tasks such as ordering and checking drugs. Having no portering system adds pressure as nursing staff have to transfer children to wards.

Staffing levels were discussed during all focus groups. We were told that across all staff groups, staffing levels are insufficient to meet service needs.

A review of staffing levels has been s carried out in all disciplines; however the recruitment process can be slow and create difficulties for new starts e.g. delayed payment.

We were told that staff could access mandatory training and additional role specific training. Some staff identified however that it can at times be difficult to secure protected time to complete online training. A supervision and appraisal process is in place and we were told by staff that it is used effectively to identify staff training needs.

We were told of future plans to build a new children's hospital. Going forward staff told us that it is important to work with the service commissioner to ensure the new build plans and changes to systems and processes are fit for purpose and take account of any future developments in the delivery of care.

Evidence of quality improvement work was provided, with staff discussing current and future initiatives including electronic prescriptions, multidisciplinary incident panels and the introduction of safety briefings.

Areas identified for further improvement included:

- staffing levels
- bed capacity
- timely discharge/repatriation of patients with suitable community care packages
- building layout and design

We have outlined in previous sections of this report, recommendations we have made and our support for work already undertaken by the trust to address these challenges.

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