The Regulation and Quality Improvement Authority

Unannounced Hospital Follow up Inspection Report
Royal Belfast Hospital for Sick Children

11 – 13 December 2017

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

Contents

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Abbreviations

ATM	Automated teller machine
BW	Barbour Ward
ED	Emergency Department
GMC	General Medical Council
IT	Information technology
PEWS	Paediatric Early Warning Scores
QUIS	Quality of Interaction Schedule
RBHSC	Royal Belfast Hospital For Sick Children
RCPCH	Royal College of Paediatric and Child Health
RQIA	Regulation and Quality Improvement Authority
SSPAU	Short Stay Paediatric Assessment Unit

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

Regulation and Quality Improvement Authority (RQIA) inspects quality of care under four domains:

- Is Area Well- Led? Under this domain we look for evidence that the ward is managed and organised in such a way that patients and staff feel safe, secure and supported;
- Is Care Safe? Under this domain we look for evidence that patients are protected from harm associated with the treatment, care and support that is intended to help them;
- Is Care Effective? Under this domain we look for evidence that the ward or unit or service is providing the right care, by the right person, at the right time, in the right place for the best outcome; and
- Is Care Compassionate? Under this domain we look for evidence that patients, family members and carers are treated with dignity and respect and are fully involved in decisions affecting their treatment, care and support.

Under each of these domains and depending on the findings of our inspection, we may recommend a number of actions for improvement that will form the basis of a Quality Improvement Plan (known as a QIP). Through their QIP the hospital and Trust will put in place measures to enhance the quality of care delivered to patients and to effectively deal with issues we have identified during inspection.

The standards we use to assess the quality of care during our inspections can be found on our website[1]. We assess these standards through examining a set of core indicators, which are also available on our website[2].

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

Together these core indicators make up our inspection framework, and this framework enables us to reach a rounded conclusion about the ward or unit or service we are inspecting.

During inspections, the views of and feedback received from patients and service users is central to helping our inspection team build a picture of the care experienced in the areas inspected. We use questionnaires to facilitate patients and relatives to share their views and experiences with us. Our inspection team also observes communication between staff and patients, staff and relatives/family members, and staff and visitors. These observations are carried out by members of our inspection team using the Quality of Interaction Schedule (QUIS) observation tool. This tool allows for the systematic recording of interactions to measure the quality of interactions.

We also facilitate meetings and focus groups with staff at all levels and all disciplines in the areas or services we inspect. We use this information to inform the overall outcome of the inspection and the report produced after the visit.

3.0 Hospital Overview

The Royal Belfast Hospital for Sick Children (RBHSC) was founded in 1879 and is one of the four hospitals within the Belfast Health and Social Care Trust (Belfast Trust). It is the only hospital in Northern Ireland dedicated to the care of children, who make up 21% of the province's population.

The hospital has 107 beds and provides general in-patient care for children living in the greater Belfast area, as well as most of the regional specialist paediatric services in Northern Ireland. The hospital's Emergency Department (ED) sees approximately 33,000 children each year.

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

4.0 Inspection Summary

RQIA carried out an unannounced inspection of the RBHSC over a period of three days from Monday 11 December to Wednesday 13 December 2017. The purpose of this inspection was to follow up on areas for improvement identified at an earlier inspection, carried out in May 2017. The following areas were visited as part of this inspection:

- Barbour Ward;
- The Emergency Department; and
- The Short Stay Paediatric Assessment Unit.

Barbour Ward

Barbour Ward (BW) is a 16-bedded surgical ward; it is the only dedicated children's surgical ward in Northern Ireland. The ward provides care for children with a wide range of age, dependencies and requirements for either general and/or specialist in-patient services. This includes children with orthopaedic, spinal, surgical and medical care needs. The ward provides care for neonates; children requiring plastic surgery; and also provides specialist renal support including regular dialysis and care for children post-transplant.

Emergency Department

The ED is the only dedicated children's ED in Northern Ireland and approximately 33,000 children are seen there each year. As well as waiting, triage and clinical treatment areas; the ED includes a two-bed resuscitation area.

Short Stay Paediatric Assessment Unit

The Short Stay Paediatric Assessment Unit (SSPAU) opened in October 2014. Its purpose is to assess, investigate, observe and treat children and young people with acute illness, injury or who have been referred by other clinicians. The unit has the capacity to care for eight children in one en-suite room, one four-bedded bay and one three-bedded bay. At the time of our inspection the SSPAU although physically separate from the ED was staffed by nurses from the ED.

4.1 Inspection Outcome

Following our inspection, we provided detailed feedback on our findings to the managers and staff on the wards we visited. This feedback, delivered by the lead inspectors allocated to each ward, highlighted the areas of good and best practice we had observed and also identified areas for improvement.

Our Director of Improvement/Medical Director provided high-level feedback on the inspection findings as a whole to the RBHSC and Trust senior and executive team. This session was attended by the Trust and RQIA Chief Executives and as well as several members of the Trust's Executive Team, minutes were recorded and subsequently shared with the Trust in December 2017.

This inspection (December 2017) was a follow up to a previous inspection undertaken in May 2017. The report of our earlier inspection can be found on RQIA's website[3]. This, our second inspection focused in detail on the environment and services delivered in BW, under the four quality domains outlined above.

[3] https://www.rqia.org.uk/RQIA/media/CareServices/020168_RBHSC_Acute_03052017.pdf

In the SSPAU we looked closely at the environment and services delivered against the Standards for SSPAUs issued in 2017 by the Royal College of Paediatrics and Child Health (RCPCH)[4]. For the ED, we determined that a second detailed inspection was not required (following our May 2017 inspection) and we therefore looked only for evidence that the Trust and the Department had made the improvements we recommended in May 2017.

RQIA acknowledges the work that the Trust and hospital staff have undertaken since our May 2017 inspection in RBHSC. The development of a new leadership structure within the hospital appears to be supported by staff at all levels, and we were told that refreshed leadership arrangements have led to improved working relationships across the hospital. Staff told us they felt more valued and appreciated and that the disconnects (between Trust management and clinical staff) previously identified were being addressed by the hospital's current senior team. We consider this to be a timely opportunity to build on the momentum staff have described to further improve the quality of care delivered within and across the hospital.

As part of our inspection policy, we have procedures in place to escalate any issues we find that are of such serious concern they require immediate attention.

During feedback to the RBHSC and Trust senior and executive team we identified and escalated six key areas for the Trust to take forward for immediate attention.

These key areas are:

- Nursing leadership on BW;
- Retention of nursing staff;
- The case mix and complexity of patients and physical environment on BW;

[4] https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

- The Short-Stay Assessment Unit;
- The opportunity to harness the enthusiasm of senior managers and clinicians to work together to deliver key improvements;
- The need for RBHSC staff and management to be fully engaged and involved in the regional work for children's services.

This report sets out an overview of our findings in each of the areas re-visited. It is not intended to repeat the detailed feedback given to ward staff and the hospital and Trust senior management team at the conclusion of our inspection.

5.0 Barbour Ward

5.1 Is the Area Well Led?

Areas of Good Practice and Improvements since our Last Visit

We were pleased that the previously vacant Ward Sister post had been filled since our last inspection. We did identify some concerns regarding leadership on the ward, these are set out below. Overall we noted this development was positive for the ward. During our visit, the Ward Sister was visible and approachable and nursing staff told us that morale on the ward was good. They told us that they felt valued and supported by the Ward Sister and they felt empowered to raise concerns should they need to.

We observed all grades and disciplines of staff working well together on the ward. The domestic services team told us that they feel valued as part of the ward team and are included in day to day running of the ward.

Nursing staff told us that meaningful and timely supervision and appraisal are supportive processes and talked positively about their experiences of both. We noted that systems are in place to ensure that staff routinely receive updates about a range of audits and assurance processes in the context of safety and achievement of key performance indicators on the ward.

Picture 1: Displayed results of performance indicator

Since our previous visit we noted introduction of a standard electronic handover document to the ward, which staff reported had resulted in handover being more efficient overall and more helpful in terms of retention of key patient-related information.

We also noted that other quality improvements had been implemented on the ward – including a “bleep free handover” period and an electronic system for discharging patients. Early indicators show that these local developments are supporting staff to deliver safer and improved quality of care to patients on the ward.

Areas for Improvement

We were concerned that the newly appointed Ward Sister was not appropriately supported in her new role. At the time of our inspection there had been no recruitment to backfill the Ward Sister’s substantive Band 6 post and the other Band 6 nurse on the ward was absent due to illness. The Ward Sister therefore had no senior support infrastructure below her. At the time of our inspection the Band 8A service manager post for this area also remained vacant, although we were advised that the candidate successfully recruited to this role would be in post in a matter of weeks (January 2018).

Regardless, inspectors felt there was a general disconnect between the Ward Sister and wider hospital processes such as easy access to staff attendance information and attendance at key meetings to share information and learning from other departments.

At our previous inspection (May 2017), we raised our concern about staffing levels on the ward. This had been identified at the time by senior clinicians. During this inspection (December 2017) the ward was calm and running well, however we remain concerned about the robustness of the overall nursing staff complement for the ward, given the case-mix, age range and patient mix on the ward and the potential impact on patient safety should a significant incident occur. Nursing staff agreed with our assessment and described considerable pressures associated with working on the ward.

Trust staff told us that two additional Band 5 nurses had been appointed to the ward following a staffing review in 2015, and that the general lack of paediatric nurses in training in Northern Ireland is an issue reflected on the Trust's Corporate risk register. We were also told that a business case for additional RBHSC nursing staff had been submitted as part of the Trust's demography proposals. This is to support future developments in children's regional services.

In respect of reporting and learning from incidents, our inspection team was concerned at the quality of some aspects of this process. In one case it was not clear that an incident had in fact occurred (i.e. that the events as described actually constituted an adverse incident) and in others cases there did not appear to be any learning identified through reporting and review of events. In one case there was confusion as to whether a root cause analysis had been or would be undertaken with a view to identifying learning. Events relating to two other incidents did not appear to have been appropriately scrutinised, events were attributed to the busy nature of the ward (and lacked evidence to support this assumption) rather than to the fundamentals of the incidents/events themselves.

Some nursing and junior medical staff reported long delays in receiving and completing their inductions to the ward as well as challenges relating to their ability to attend mandatory training courses.

Actions for Improvement

RQIA recommends the following to improve the leadership for and on the ward:

1. **The Trust should move to permanently appoint a Ward Sister to BW and take steps to ensure the Ward Sister's role is appropriately supported by suitably skilled permanent staff at lower and higher grades.**

2. **The Ward Sister on BW should have protected time to undertake the managerial duties of the post.**

3. **Ward staff on BW should ensure that incident reporting forms are comprehensively completed and investigated with learning identified. The Trust should ensure there is an appropriate system in place to assure effective completion of incident reporting, investigation and identification and dissemination of subsequent learning.**

5.2 Is Care Safe?

Areas of Good Practice and Improvements since our Last Visit

The ward was cleaned to a high standard as before and we noted good practice by ward staff in hand washing and in the use of personal protective equipment (PPE) such as disposable aprons and gloves.

We noted that a large container has been provided for parents/carers and children to store their belongings. This has helped reduce clutter in the ward and to assist with cleaning.

In contrast to our previous inspection (May 2017), we were provided with evidence of water testing and maintenance for the ward. These measures reduce the risk of organisms such as *Legionella* and *Pseudomonas aeruginosa* potentially compromising patient safety.

We noted good practice in the labelling of invasive lines and tubes, in line with the regional policy which is designed to reduce the risk of wrong route administration of medicines. We also observed daily checks of the resuscitation trolley, in line with good practice.

We observed the morning safety brief and noted that it was well-facilitated, concise and effectively delivered key messages to all staff.
Paediatric Early Warning Scores (PEWS) charts were in place and completed correctly. We found evidence that actions taken to address increased PEWS scores were appropriate and clearly documented in the care record.

The ward's full-time pharmacist is responsible for each patient's medicines reconciliation at admission, during their in-patient stay and at discharge.

Areas for Improvement

In our previous inspection we noted the challenges experienced by staff in relation to the diverse mix of patients receiving care on the ward. We were therefore concerned to find that this had not changed since our previous inspection and in fact we were further concerned about the temporary relocation of the cardiology investigations service to the "pod" area of the ward, further limiting the ability of staff to assess and plan to reconfigure the ward going forward.

The ongoing absence of a system to monitor antimicrobial prescribing and stewardship on the ward remains an issue. We were told that this had also been flagged during recent work by Internal Audit and measures were underway to mitigate the risks identified – including securing funding through development of a business case for an additional Consultant for Infectious Diseases and additional dedicated pharmacist input for antimicrobial stewardship work.

As at our previous inspection there was still no call bell system in the area of the ward used for children with high dependency care needs, meaning that children and their families had no way to call for assistance should there not be a staff member in their immediate vicinity.

Despite there being dedicated pharmacist input to the ward, the pharmacy refrigerator was not properly managed, with the temperature noted as frequently outside the required range. Some medicines were noted to be out of date, others did not require cold storage at all (although they were stored in the refrigerator) and some medicines had been opened and were not dated appropriately.

Whilst hand hygiene practice was generally observed as good, our inspection team observed two consultants not in complying with the Trust's bare below the elbow policy. This is particularly concerning given the patient mix on the ward and the concerted work progressed by the Trust over recent years to address the risk of healthcare associated infections.

We found that documentation in respect of the insertion and removal of peripheral vascular catheters was not always completed to the required standard. Again this is a particular concern given the Trust's work to address the risk of healthcare associated infections.

Actions for Improvement

RQIA recommends the following to improve the delivery of safe care on the ward:

4. **The Trust should review and clarify the model of care, case mix and complexity of patients receiving care on BW. Hospital management must reconsider the use and configuration of space available in BW and future plans for the care delivered on the ward.**

5. **Ward staff and pharmacy staff on BW should ensure that medicines are stored correctly, in line with best practice guidance. Variations outside refrigerator temperature ranges should be immediately actioned. Hospital management should ensure there is an appropriate system in place to assure adherence to best practice.**

6. **Ward staff on BW should ensure completion of documentation in respect to insertion and removal of peripheral vascular catheters. Hospital management should ensure there is an appropriate system in place to assure completion of documentation.**

5.3 Is Care Effective?

Areas of Good Practice and Improvements since our Last Visit

Throughout our inspection the children receiving care on BW appeared comfortable and told us that they were pain free, we saw an appropriate variety of evidence-based scoring models in use to assess children's pain. These models took account of the child's age and level of understanding. Parents/carers told us that staff responded to their children's needs in a timely manner.

A variety of pressure relieving equipment was in place and used effectively, and skin care bundles were in place and evidenced for children at risk of developing pressure damage.

We observed the meals service and noted that meals were served warm and appeared appetising. There were sufficient staff to assist children who needed help and disruption during meal times was kept to a minimum. Parents/carers were offered meals on request. We noted that fluid balance charts were in use and very comprehensively completed.

Areas for Improvement

Areas for improvement in the domain centred on documentation and evidencing of care provided for children. Whilst nursing and other ward-related risk assessments were well completed, we found that information was not always used to inform care planning. This was also the case on our previous inspection.

As previously, we noted that medical entries in the patient notes did not always meet General Medical Council (GMC) requirements. We also found, once again, limited evidence in the care records of communication with parents/carers – although parents/carers who provided feedback to our inspectors reported that communication with them was good.

Actions for Improvement

RQIA recommends the following to improve the effectiveness of care on the ward:

7. **All nursing staff on BW should ensure patient care planning is informed by nursing and risk assessments. Hospital management should ensure there is an appropriate system in place to assure completion of nursing care plan documentation.**

8. **All medical staff on BW should ensure medical entries in patient notes are clear, accurate and legible in line with GMC requirements. Hospital management should ensure there is an appropriate system in place to assure adherence to GMC requirements.**

9. **All staff delivering care on BW should ensure comprehensive document of communication with parents/carers in relation to patient care. Hospital management should ensure there is an appropriate system in place to assure documentation of communication with parents/carers.**

5.4 Is Care Compassionate?

Areas of Good Practice and Improvements since our Last Visit

Throughout our inspection we observed staff at all levels who treated children and their parents/carers with kindness and respect whilst delivering care and treatment in a compassionate and committed manner. Feedback from parents/carers about care their child received/was receiving was consistently good.

We noted staff working to maintain the dignity and privacy of each child. Children and parents/carers from differing cultures, backgrounds and religions were appropriately supported.

The ward's open visiting policy, as well as the availability of dining facilities during the day, and car parking and meal vouchers (for families who may need them) were found to contribute to the overall ethos of compassionate care on the ward.

The benefit of the ward's dedicated play therapist was noted, specifically to help children deal with any fears and anxieties by making sense of what might be unfamiliar or frightening environments in the acute hospital setting.

Areas for Improvement

Whilst feedback about the quality and ethos of care delivered on the ward was positive overall, parents/carers did raise a number of very practical issues. These included a lack of overnight beds or chairs suitable for sleeping on; a lack of out-of-hours catering facilities and poor access to an ATM. These issues were identified during our previous inspection (May 2017) and are practical matters which are expected to be reasonably simple to resolve in most cases. Our inspection team was disappointed therefore that the Trust's response to our previous recommendation in this area has been only to benchmark provision against that available elsewhere such as providing charging points for mobile phones.

Action for Improvement

RQIA recommends the following to improve the compassion in care delivered on the ward:

10. **The Trust should improve services available for parents/carers on BW and beyond. This should include the provision of overnight beds and chairs, access to out of hours catering and banking facilities and areas for improvement identified through benchmarking and engagement with parents/carers.**

6.0 Short Stay Paediatric Assessment Unit

In general, we found care delivered in the SSPAU to be good. We observed that staff introduced themselves in line with the "Hello, my name is….." initiative which the Trust has endorsed and we saw friendly yet professional interactions between staff, their patients and parents/carers. Staff responded quickly to requests from patients and/or parents/carers and gave clear explanations regarding the care they delivered.

As in our previous inspection (May 2017) we were concerned that at the time of this inspection this unit is not operating as an actual SSPAU. This was a key finding in our previous inspection and our inspection team was disappointed by the lack of progress made in key areas such as governance, referral and admission criteria and pathways, and the physical environment in which the SSPAU is currently sited in the hospital. It is our view that at the time of this inspection the SSPAU in RBHSC is operating as a medical ward rather than a short stay assessment unit – our view is evidenced by the five of eight children on the SSPAU for more than 48 hours (at the time of our inspection) and one child had been there for more than five days.

The key findings from our inspection of the SSPAU are presented below against the relevant standards as advised by the Royal College of Paediatrics and Child Health (2017)[5].

Governance

RCPCH Standard 2: A standard operating policy must be in place with a named senior paediatrician and a named senior children's nurse responsible for the management and co-ordination of the service.

[5] https://www.rcpch.ac.uk/sites/default/files/SSPAU_College_Standards_21.03.2017_final.pdf

We identified that whilst there was a standard operating policy in place for the SSPAU; there was no single senior Consultant Paediatrician responsible for the management and co-ordination of the Unit. Children in the SSPAU are under the care of a number of different clinicians and the senior nurse responsible for the Unit is the ED Sister, nurse staffing for the Unit is provided from the ED. The SSPAU therefore does not have dedicated senior staff responsible for management and co-ordination of the service delivered. Staff advised that they are able to access appropriate clinical support as necessary for care of individual children. However this is not the same things and does not fulfil the required standard regarding SSPAU governance.

The lack of oversight by dedicated senior staff (i.e. Consultant Paediatrician and named senior nurse) presents what we consider to be a serious governance risk to the running of the SSPAU.

Referral and Admission Pathways

RCPCH Standard 3: Clear pathways for access, referral and admission to the SSPAU (including defined inclusion and exclusion criteria) and for escalation of care and discharge must be in place and audited against.

The nurse in charge of the SSPAU told us that the Unit had been reviewed against its standard operating procedures during the first year of its establishment (i.e. 2014/15) but since then there had been little monitoring of performance.

As outlined above, it is the view of our inspection team – supported by the numbers of children in the Unit for longer than 48 hours – that at the time of this inspection the SSPAU is providing additional medical in-patient capacity to relieve pressures on beds in the hospital, rather than functioning as a dedicated SSPAU providing short-stay care for children.

This does not align with the Unit's own operational policy. The Trust must determine the designation and function of this Unit.

The Trust's senior management team highlighted challenges in operating the Unit as an SSPAU given the current absence of a regional approach to acute bed management in children's services. We were also told of the planning and building of a new children's hospital and how this presents a limit to the changes that can be applied in the interim in RBHSC. Whilst acknowledging and understanding these issues, we remain concerned at the overall lack of governance and clarity of purpose of the SSPAU as it currently operates.

Performance Audits

RCPCH Standard 7: Each SSPAU audits their performance against locally agreed care quality indicators.

We were unable to find any evidence of the existence of agreed quality indicators or routine audits to evidence and assure performance of the SSPAU.

Environment

RCPCH Standard 13: SSPAUs which provide care for infants, children and young people beyond four hours must include provision for meals, bathroom and parent facilities.

Picture 2: Short Stay Paediatric Assessment Unit

The current physical environment of the SSPAU is less than ideal. The core clinical space between patient beds and cots is extremely limited, some parents/carers commented about the lack of space within the Unit and provided feedback on how this lack of space affects or has affected their child.

The sanitary facilities on the Unit are insufficient with just one toilet for patients, relatives and staff to share. There are no shower facilities so patients and relatives have to move to other wards to shower.

There are also no catering facilities for parents/carers on the Unit although we note that staff can and do provide parents/carers with tea and toast.

Largely due to a lack of storage space the Unit is cluttered. This makes it difficult for staff to clean effectively.

When we discussed these issues with the Trust's senior team at the conclusion of our inspection, it was not clear how the Trust intends to resolve the challenges associated with the present location and structure of the SSPAU.

Actions for Improvement

RQIA recommends the following to improve the leadership and governance of care delivered on the Unit:

1. **The Trust should put in place a named senior paediatrician and a named senior children's nurse responsible for the management and co-ordination of the service on the SSPAU.**

2. **The Trust should review and clarify the model of care within the SSPAU. Clear pathways for access, referral and admission to the SSPAU should align with the Units operating policy. Hospital management should ensure that there is an appropriate system in place to assure and govern functioning of this Unit.**

3. **The Trust should agree and introduce quality care indicators supported with a routine programme of audit within the Unit. Hospital management should ensure that there is an appropriate system in place to assure the quality of care delivered on the Unit.**

4. **The Trust should improve services available for parents/carers in the SSPAU and beyond. This should include a review of space utilisation, the provision of sanitary facilities and access to catering. Areas identified for improvement through benchmarking and engagement with parents/carers should be implemented.**

7.0 Emergency Department

Our inspection of the ED was designed only to follow up on the areas for immediate improvement cited in May, as we determined that a second detailed inspection was not required, we therefore looked only for evidence that the Trust and the Department had made the improvements we recommended previously. Overall we were pleased that most of the issues identified previously had been addressed and no new issues were identified.

During our visit, the ED was busy but functioning effectively and we saw evidence of strong nursing leadership. We noted that the equipment shortages previously identified had been addressed.

Picture 3: Proposed area for second triage

We were told of plans to use the staff room and minor injuries room as a second triage area during times when the ED becomes particularly busy and we also particularly noted the new electronic information board in use in the department's waiting room. This provides comprehensive and up-to-date information on health and well-being for families waiting to be treated.

There was good patient flow through the department and we noted that several white board meetings are held every day to facilitate and manage. We were told that each patient in the department is reviewed at least hourly and more frequently if/as required.

We noted that a revised safety brief was in use, as the previous version had not met its stated objectives. We were told that the new version has improved communication between staff.

We noted that a cycle of PEWS audits had been completed and action plans developed to address any deficits identified. We also noted the introduction of a new IT safeguarding reporting system.

In another improvement since our last inspection (May 2017), information in respect of end of life care had been updated; the name of the Trust's bereavement co-coordinator had been circulated; and the ED had identified a link bereavement nurse. These are all positive developments which our inspection team expects will make care more compassionate at the most difficult time for parents/carers and families.

We noted that previous issues identified in respect of filing of patient records had been addressed and work was progressing in preparation for the introduction of an electronic tracking system for patient records across the hospital.

The nurse in charge of the ED has signalled she is due to retire imminently and the Trust had identified plans to address this personnel change.

As at our last visit there was no dedicated pharmacist input to the ED and no integrated medicines management service was implemented.

Our inspection team was somewhat concerned that the medical staff in the ED reported they had not had sight of the written summary of findings from our May 2017 visit – although the nurse in charge was aware and had received a copy of same. We discussed this during our feedback to the Trust and RBHSC Executive Team and noted that this may have arisen consequent to a misunderstanding regarding inspection feedback.

Actions for Improvement

There were no new/additional areas for improvement recommended during this follow-up visit to the ED.

8.0 Conclusion

We acknowledged the work that has been done within the hospital since on inspection May 2017, particularly development of a new leadership structure. We also acknowledge and support the need for a co-ordinated regional approach to children's services. This should ease some of the pressures presently experienced by the RBHSC. However, we were concerned the lack of progress made particularly in relation to staffing issues, the general use of BW and functioning of the SSPAU.

We determine that the development of a new leadership model and willingness of staff and managers to work together presents a unique opportunity to address issues involving BW and the SSPAU.

In order to assist and encourage the Trust to maintain this momentum and to promote a quality improvement approach, we will, over the coming months, meet on a regular basis with the Trust to assure implementation of these recommendations.

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