Unannounced Follow up Inspection Report 1-5 April 2019

Belfast Health & Social Care Trust
Hospital: The Royal Hospital for Sick Children
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Abbreviations

Belfast Trust	Belfast Health and Social Care Trust
DPU	Day Procedure Unit
ED	Emergency Department
FBC	Fluid Balance Chart
HAPPI	Hospital Antibiotic Prudent Prescribing Indicators
ID	Identification
IPC	Infection Prevention and Control
IV	Intravenous
M & M	Morbidity and Mortality
MDT	Multidisciplinary Team
NIMDTA	Northern Ireland Medical and Dental Training Agency
OPD	Outpatients Department
PACE	Person Centred, Assessment, Plan of Care, Evaluation
PEWS	Paediatric Early Warning Scores
PICU	Paediatric Intensive Care Unit
QIP	Quality Improvement Plan
RBHSC	Royal Belfast Hospital for Sick Children
RQIA	Regulation and Quality Improvement Authority
SEA	Serious Event Audit
SSPAU	Short Stay Paediatric Assessment Unit

It should be noted that 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 on 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 from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of the hospital

The Royal Belfast Hospital for Sick Children (RBHSC) was founded in 1879 and is one of four hospitals located within the Royal Victoria Hospital, Belfast Health and Social Care Trust (Belfast Trust). It is the only hospital in Northern Ireland dedicated to the care of children.

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 for Northern Ireland.

Specialist paediatric services provided in the hospital include neurology, intensive care, endocrinology, dermatology, trauma and orthopaedics, and neonatal surgery.
The Hospital's Emergency Department (ED) assess and treats approximately 33,000 children each year.

Picture 1: RBHSC Entrance

3.0 Service details

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

4.0 Inspection summary

An unannounced inspection of RBHSC took place from Monday 1 April to Friday 5 April 2019.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

During the inspection our teams visited wards and specialists services across the hospital: they included:

- Emergency Department (ED)
- Barbour Ward and Short Stay Paediatric Assessment Unit (SSPAU) to follow up on previous inspection findings
- Allen Ward
- Haematology Unit
- Paul Ward
- Knox Ward
- Belvoir Ward
- Clarke Clinic
- Day Procedure Unit (DPU)

- Haemodialysis Unit
- Paediatric Intensive Care Unit (PICU)

Our multidisciplinary inspection team examined a number of aspects of the ward and departments across the hospital, from front-line care and practices, to management and oversight of governance across the organisation.

We met with various staff groups, spoke with patients and their relatives, observed care practice and reviewed relevant records and documentation used to support the governance and assurance systems. Our team held meetings and focus groups with a range of staff and disciplines within the hospital, including the Chair and Deputy Chair of Trust Board. Our lay assessors met and spoke with relatives and a small number of patients.

During this inspection staff engaged well with the inspection team. We found that staff where dedicated to delivering patient centred care. Inspectors observed good engagement with parents/carers and involvement of families in their children's care. Advice and support information was available for parents/carers.

Inspectors noted a number of additional posts including Band 6 nurses and an additional Band 8a pharmacist had been recruited to the hospital since the last inspection. Staff provided inspectors with positive feedback in relation to their experiences of the hospital's Leadership Team. They told us they felt supported by the leadership team who they described as visible, open, and engaging. Staff morale appears to have improved since our last inspection in December 2017.

We found that the new collective leadership model established approximately two years ago was having a positive impact. A positive culture was being promoted and staff morale appeared to be improving. The collective leadership team demonstrated a clear understanding of the challenges faced by the hospital and the work required to deliver improvements across the services.

During this inspection we identified that improvement was required across of the following key areas: purpose and leadership, patient safety system; 'end of ward' or 'part of ward' services, space utilisation and environment, safe care on the wards; medicines management and record keeping.

There was not a consistent and clear understanding among staff and management as to the overall purpose of the hospital in the context of its range of functions and services. We determined that work was required to clarify which services are secondary care services for the Belfast Trust population and which services are provided on a regional basis.

We found that further work was required to strengthen and embed and overarching 'Patient Safety System' which is multidisciplinary in ethos and in practice. Once such a system is established, the leadership team should then prioritise the many quality and safety issues, identifying adequate resources to support quality improvement as well as assuring itself that improvement plans are both targeted appropriately and effective.

Inspectors noted a number of services provided within wards not aligned to the other services within the ward It was not clear that there was a system for robust oversight and governance for these 'end of ward' or 'part of ward' services across the hospital.

A governance framework and robust oversight of these services is essential to ensure that specialist nurses working within these environments have regular supervision, assessment against specified competencies, and the requisite skills and knowledge to ensure fitness to practice and public protection.

We identified a number of action plans, arising from incident investigations that were not always detailed, had no clear outline of staff responsibilities and time frames for achievement, where actions remained outstanding and that often failed to identify or report any learning.

We found that the overall purpose and function of SSPAU within the hospital remains unclear and that, arrangements for medical leadership within this ward, through a locum consultant, were not working sufficiently well.

We found that the physical environment and layout of Barbour ward continued to pose a risk to the delivery of safe, effective and well-led care and that there was not a clear plan to mitigate these risks. These risks are of particular concern given that Barbour Ward is the only dedicated surgical ward for children in Northern Ireland. We were advised that any infrastructural development of the ward had not progressed due to a number of constraints. Following this inspection, in September 2019, the trust provided us with assurances that a number of control measures had been taken to reduce the identified risks posed by the physical environment and layout of Barbour ward and ensure the safety of patients.

In relation to medication management, inspectors observed good practice in relation to administration of medications, completion of kardexes and management of controlled drugs. However, improvement is required to ensure the segregation and storage of medicines and prudent antibiotic stewardship.

Overall, we found the leadership team were fully sighted on the range of issues identified during this inspection. Frontline staff were very committed, fully engaged and motivated to commence work to undertake the required improvements. In particular we recommend that particular focus be given to alignment of various strands of improvement work with priorities identified and directed by the leadership team within the hospital.

This report provides an overview of our findings in each of the themes emerging from the inspection.

Reports from previous inspections are available on our website https://www.rqia.org.uk

4.1 Inspection outcome

We identified that improvement was required across a number of key areas, these related to:

- governing systems and processes
- purpose and leadership
- patient safety systems
- space utilisation and environment (Barbour ward and Short Stay Paediatric Assessment Unit)
- safe care on the wards
- medicines management

- record keeping

We identified a number of areas of good practice across a number of key areas, these related to:

- staffing levels and staff morale
- safeguarding
- patient centred care
- infection prevention and control and environmental cleaning
- nutrition and hydration

Following this inspection, on the 5 April 2019, we provided detailed feedback on our findings to managers and staff on the wards and departments we visited. This feedback highlighted areas of good practice and identified areas for improvement. Our Director of Improvement/Medical Director provided high-level feedback to the senior management team in the RBHSC and Belfast Trust. Minutes of this meeting were recorded and subsequently shared with the Trust in June 2019.

Total number of areas for improvement	6

At this feedback session we discussed the actions which are required with the Quality Improvement Plan (QIP).

5.0 How we inspect

Prior to inspection a range of information relevant to the service was reviewed, including the following records:

- previous inspection reports
- Serious Adverse Incident notifications
- information on concerns
- information on complaints
- other relevant intelligence received by RQIA

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

- Is the Area Well-Led? Under this domain we look for evidence that the ward or department 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.
- 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 (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 challenges 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. Together these core indicators make up our inspection framework, and this framework enables us to reach a rounded conclusion about the ward, 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 observed communication between staff and patients, staff and relatives/family members, and staff and visitors. Members of our inspection team use the Quality of Interaction Schedule observation tool carry out these observations. This tool allows for systematic recording of interactions to enable assessment of the overall quality.

We also facilitate meetings and focus groups with staff at all levels and across all disciplines in the areas or services we inspect. We use information and learning arising through their discussions to inform the overall outcome of our inspection and the report produced following the visit.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in progress.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection on 11 to 13 December 2017

The previous inspection of the RBHSC was an unannounced inspection undertaken 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.

The completed QIP was returned by the Trust to RQIA and was subsequently approved by the inspector.

[1] https://www.rqia.org.uk/guidance/legislation-and-standards/standards/

Areas for improvement from the last inspection		Validation of compliance
Barbour Ward		
Area for Improvement 1 **Ref**: Standard 4.1 Criteria 4.3 (j) **Stated:** Second time	The Trust should move to permanently appoint a Ward Sister to Barbour Ward and take steps to ensure the Ward Sister's role is appropriately supported by suitably skilled permanent staff at lower and higher grades.	**Met**
	Action taken as confirmed during the inspection: We confirmed that a permanent Band 7 Ward Sister is in post and up to date at the time of inspection.	
Area for Improvement 2 **Ref**: Standard 4.1 Criteria 4.3 (j) **Stated:** Second time	The Ward Sister on BW should have protected time to undertake the managerial duties of the post.	**Met**
	Action taken as confirmed during the inspection: Ward sister confirmed sufficient protected time to carry out the managerial duties of the role.	
Area for Improvement 3 **Ref**: Standard 5.1 Criteria 5.3.2 (c) **Stated:** Second time	Ward staff on Barbour Ward 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.	**Met**
	Action taken as confirmed during the inspection: We confirmed that the trust has reviewed and updated staff on the management of incidents. Learning is disseminated to staff at safety briefs and staff meetings.	
Area for Improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1 (e) **Stated:** First time	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.	**Not Met**
	Action taken as confirmed during the inspection: We were informed that capital investment is required and decant of the ward to an alternative place for a period of time for achievement of this area for improvement.	

Area for Improvement 5 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A system has been introduced to ensure medicines are stored correctly in line with best practice guidance and variations are acted upon.	
Area for Improvement 6 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Confirmed that a system is in place to audit, report and action issues identified in the management of invasive devices.	
Area for Improvement 7 **Ref**: Standard 5.1 Criteria 5.3.1 (a) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Confirmed that a system are in place to audit, report and action issues identified in the completion of nursing care planning and risk assessment.	
Area for Improvement 8 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Confirmed that a system is in place to audit, report and action issues identified with medical records.	
Area for Improvement 9 **Ref**: Standard 5.1 Criteria 5.3. 2 (d)	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.	**Met**

Stated: Second time	**Action taken as confirmed during the inspection**: Confirmed that a system is in place to audit, report and action issues identified to ensure comprehensive document of communication with parents/carers in relation to patient care.	
Area for Improvement 10 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First time	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.	**Partially Met**
	Action taken as confirmed during the inspection: Confirmed the purchasing of overnight beds and chairs, ATM installed, reviewing catering services with access to tea, coffee and toast. Patient experience feedback surveys introduced which include questions on areas for improvement, time required to embed in practice.	
Short Stay Paediatric Assessment Unit		
Area for Improvement 1 **Ref**: Standard 5.1 Criteria 5.3.3 (f) **Stated:** Second Time	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.	**Partially Met**
	Action taken as confirmed during the inspection: We confirmed ward sister in post. Named paediatrician in place to further develop this role.	
Area for Improvement 2 **Ref**: Standard 5.1 Criteria 5.3.3 (f) **Stated:** Second Time	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.	**Partially Met**
	Action taken as confirmed during the inspection: Work has commenced in this area.	
Area for Improvement 3 **Ref**: Standard 5.1 Criteria 5.3.3 (f) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: We confirmed that quality care indicators were in place and reported on.	

Area for Improvement 4 **Ref**: Standard 5.1 Criteria 5.3.3 (f) **Stated:** Second time	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.	**Partially Met**
	Action taken as confirmed during the inspection: Work is in progress to move the SSPAU to a newly refurbished part of the hospital.	

6.2 Inspection findings

6.3 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

6.3.1 Governance systems and processes

During the inspection, we assessed how the leadership, management and governance of the hospital assures the delivery of high quality care. We sought evidence that patients and staff are safe, secure and supported, the promotion of and open and transparent culture and a culture of learning and innovation.

The new collective leadership model, established across the Trust approximately two years ago, was found to be having a positive impact. Staff reported that it had contributed to a culture which was open and that the leadership team were accessible. Staff reported that morale has improved since the previous inspection. The collective leadership team demonstrated a clear understanding of the challenges they face and the work required to bring forward further improvements across the services. We were encourage by the positive way in which the collective leadership model was perceived and encouraged both clinical teams and mangers to capitalise on the opportunity to embed lasting change within the service.

The following key issues were identified:

6.3.2 Purpose of hospital and leadership

During the inspection, it was not possible to clearly identify what the overall purpose of the hospital was in respect of its numerous functions. Some of these functions are regional, and specialist as part of the hospitals role as a tertiary care service and some are secondary care services for the Belfast Trust.

As many patients from outside the Trusts resident population present at the ED within the Hospital, and are subsequently admitted, it was not always clear whether a local or regional specialist service was being provided and whether options for admission in an alternative local hospital had been fully considered in all cases. In addition we did not find evidence of clear alignment and integration between the local primary care services, provided within the community across the Belfast Trust and the secondary care hospital services within the Hospital.

Identification and clear delineation of services which are regional and specialist and which are local for residents of the Belfast Trust is particularly important for the functioning and forward planning of the ED within he hospital and the subsequent impact on unscheduled/acute bed usage within the hospital.

We found that within some condition specific tertiary care services, there was evidence of good practice regarding regional collaboration in respect of pathways of care e.g. centralisation of paediatric cardiac services.

Further work will be required to agree and establish the hospital as the regional hub of a hub and spoke model. The Trust should work closely with the newly established Regional Child Health Partnership and show the required leadership in shaping future models of care for paediatric services. We encouraged the RBHSC clinical and managerial teams to show the required leadership in working collaboratively with all of the other Trusts to further develop regional pathways.

6.3.3 Patient safety system

Many of the constituent parts of a patient safety system were present, some are top down and some bottom up initiatives.

We saw evidence of number of safety initiatives aimed at enhancing teamwork, co-operative problem solving and situational awareness such as daily ward safety briefs and monthly live governance, audit and assurance meetings. Training had been targeted to support staff in incident management and trend analysis and a programme of audits across areas such as preventing patient deterioration, sepsis and healthcare associated infections. Additionally we observed evidence of audits of documentation which included nursing and medical care plans and fluid balance charts.

We did not, however, find a clear overarching patient safety strategy. We advised the senior leadership that an overarching ‘Patient Safety System’ is required which is multidisciplinary in ethos and in practice. The monthly governance forum has overall responsibility to design and implement an overarching system. We found that this group appeared to be receiving updates and an overview of the current range of activities underway, rather than directing and prioritising these activities. Once such a system is established it is advised to set about prioritising quality and safety issues, identifying governance resources to support quality improvement as well as assuring itself that improvement plans are appropriate and effective. A key constituent of the safety system should be a remodelled Morbidity and Mortality meeting which is multidisciplinary, rather than medically focussed, and with a stronger safety element. This would enable all professional groups to see, participate in, shape and drive improvements.

6.3.4 'End of ward' or 'part of ward' services

Specialist nurses are nurses who have advanced skills in a particular area of practice. They frequently take a lead role in the delivery of aspects of a patient's care and treatment.

We engaged with a number of specialist nurses during our meetings and inspections. We identified a number of 'end of ward' or 'part of ward' services delivered on wards and departments by specialist nurses but not included in governance and management systems relating to that ward. Inspectors were unable to determine a system for robust oversight or an overarching governance framework for these 'end of ward' or 'part of ward' services across the hospital.

In Paul Ward, Allen ward and Clark clinic senior staff advised they have no responsibility or oversight of the care delivered by specialist nurses working within the patient treatment rooms in these wards. We were advised that supervision of these specialist nurses does not routinely involve peer review of case notes or review patient outcomes. Appraisal and agreement of personal development plans are generally undertaken in a uni-professional rather than multi-professional manner (service aligned medical staff are generally not involved in appraisal). We advised the leadership team that a governance framework and robust oversight of these services is essential to ensure that specialist nursing roles have regular assessment against specified competencies, skills and knowledge to ensure fitness to practice and public protection. Systems of support should be strengthened for this staff group in relation to supervision, appraisal, professional development and revalidation. We determined that the care delivered by specialist nurses in the RBHSC requires closer oversight and monitoring.

6.3.5 Incident reporting

During the inspection, we reviewed the systems in place to identify safety issues, record incidents and near misses arising in the hospital and how staff report and respond to these incidents.

We identified a number of incident action plans that were not sufficiently detailed, had no clear outline of staff responsibilities and time frames for achievement, were actions remained outstanding and were they failed to identify any learning from the incident.

- Paul Ward - A Significant Event Audit (SEA) was carried out relating to the care of a child. The detail within the action plan of this incident is limited, with no clear outline of staff responsibilities and time frames for achievement. When this incident was discussed with staff there was a lack of awareness of this incident or any learning generated.

- Knox Ward – Two of three recommendations from an SEA, which occurred relating to a deteriorating patient, remained outstanding at the time of the inspection. Clear timescales to achieve the recommendations required, had not been documented.

On discussion with staff we noted occasions were staff lacked awareness of the incidents which related to their areas or any related learning. Junior medical staff told us that nursing staff occasionally submit an incident report in relation to a medication error without informing medical staff involved. Medical staff told us they rarely receive feedback regarding incidents and there is no formal forum that junior doctors can attend and discuss incidents and associated learning.

We determined that the systems intended to ensure that information and learning is shared across and within teams was not fully effective and did not ensure information was provided to clinical teams in a timely way.

6.3.6 Staffing

Inspectors noted a range of proactive actions taken by management to address staffing challenges. We noted an increase in the number of staff, including additional Band 6 nurses and an additional Band 8a pharmacist, recruited to the hospital since our previous inspection. Where deficits in staffing had been identified, we noted the use of nursing bank staff who were blocked booked to ensure consistency in personnel.

Staff told us that managers were visible, approachable and responsive and encouraged a culture centred on the needs of patients and the wellbeing of staff. Staff reported feeling respected and valued by managers which helped to promote a culture of respect, candour, openness and honesty.

Throughout all wards and departments visited we reviewed records to indicate that staff were supported to deliver effective care and treatment through meaningful and timely supervision and appraisal. Staff talked positively about their experience of supervision and appraisal and the support from line managers to carry out their role. Appraisal was viewed as a mechanism for a member of staff to allow staff to fully understand their contribution to the corporate objectives which are delivered through the services in which they work.

Morale was noted to be good amongst medical doctors in training, who reported being well supported in their decision-making and management of patients. We found adequate medical staff levels throughout wards and departments with actual staffing levels comparable to planned levels. Where deficits in the medical rota were identified, locum staff filled shifts, adequate cover was reported. Doctors in training reported they received a comprehensive induction to the hospital.

We observed effective communication between and within staff groups both during and outside of meetings and ward rounds. Staff reported they can readily access the information they need to assess, plan and deliver care to children in a timely way. Information about safety was comprehensive, timely and discussed in all wards during safety briefs. Systems were in place to securely and safely manage the challenge of using both electronic and paper-based systems.

Space utilisation and environment

6.3.7 Short Stay Paediatric Assessment Unit (SSPAU)

In previous inspections, we identified governance and leadership, referral and admission criteria and the physical environment of SSPAU as key areas were improvement was required.

We found that there have been new senior nurse appointments resulting in an improvement in the quality of nursing leadership in SSPAU. It was also evident that staff were committed to the development of the SSPAU and its relocation to a more suitable environment within the hospital. We found evidence that some work has been undertaken to update the unit's admission criteria and to introduce key performance indicators relating to the unit's function.

We found that the overall purpose and function of SSPAU within the hospital remains unclear and arrangements for medical leadership, through a locum consultant, were not working sufficiently well.

During this inspection we requested that the trust submit an action plan detailing a clear description of the purpose of the unit and its functions, and how SSPAU interacts and partners in other services within hospital.

Following this inspection, we met with Trust senior management representatives in August 2019 and received information of ongoing actions taken to address concerns in relation to SSPAU. We were assured by the information received that there has been sufficient progress in defining a clear purpose and function of the SSPAU, with clear medical leadership. We noted that plans are progressing to move the SSPAU to the newly refurbished old Paul ward with an initial completion date of the end of February 2020.

6.3.8 Barbour Ward

During previous inspections and subsequent progress monitoring meetings, we raised concerns about nursing leadership and retention of nursing staff on the ward and the standard of the environment of Barbour ward to cater for the different age ranges, acuity and multi-specialty of complex conditions.

We were pleased to note nursing staffing levels have improved and that staff morale had improved. Inspectors observed all grades and disciplines of staff communicating and working well together.

We found that the physical environment and layout of Barbour ward continued to pose a risk to the delivery of safe, effective and well-led care. These risks are of particular concern given that Barbour Ward is the only dedicated surgical ward for children in Northern Ireland. Our specific concerns included:

- Safeguarding risks due to the inability to segregate children of different ages and gender.
- The negative experience of patients due to the physical infrastructure in relation to maintaining dignity and privacy.
- Lack of a call bell system in the area used for children with high dependency care needs.

During both previous inspections, this inspection and during our monitoring meetings we were advised by Belfast Trust representatives that plans to improve the layout and design of the ward were progressing and preparatory steps had been taken. We were advised that two options were identified regarding the refurbishment work and the decanting of patients to other areas of the hospital to allow for work to commence. We were informed that finance had been secured to support either option and work would be undertaken during financial year 2017-18.

Following this inspection, we received correspondence in August 2019, which advised there have been a number of constraints that have made it difficult to progress with infrastructural development of the ward. In the interim, the Trust and the Department of Health have continued to engage in optimising the use of allocated funds for the infrastructural development of the ward while taking into account the development of the new children's hospital. Having considered this development, we have received assurances in September 2019 that a number of control measures had been taken locally to reduce the identified risks posed by the physical environment and layout of Barbour ward and ensure the safety of patients.

Areas of good practice

Staff morale had improved since the last RQIA inspection in December 2017. We found that staff within wards and departments understood their respective roles and responsibilities and felt empowered to raise concerns. Managers were visible, approachable and responsive and encouraged a culture centred on the needs of patients and the wellbeing of staff.

Areas for Improvement

Areas for improvement were identified in relation to clarifying the overall purpose of the hospital, governance and assurance systems of 'End of Ward or 'Part of Ward' services, establishing a patient safety system, incident reporting and space utilisation and environment of Barbour ward and the Short Stay Paediatric Assessment Unit.

Number of areas for improvement	3

6.4 Is care safe?

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

As part of the inspection we looked for evidence that patients are protected from potential harm associated with the treatment, care and support.

6.4.1 Environment

During previous inspections, we found that many parts of the original RBHSC building are old and difficult to maintain. There were significant challenges to accommodate children, parents, visitors, and regional services within the current footprint of the hospital. We found that available space is currently optimized by staff in order to cater for the increasing demand on RBHSC and its services.

The functional and practical requirements of the wards and departments throughout the RBHSC were not being fully met by their design and layout resulting in a challenging environment in which to deliver modern healthcare services. The higher operational, maintenance and energy costs of the current hospital building combined with the need to expand the footprint of the hospital to provide higher quality facilities and services with improved functionality resulted in approval of funding for the development of a new regional Children's Hospital.

The new Children's Hospital is planned to be located on a site adjacent to the existing RBHSC, with bridge links to some of the other hospitals on site including the Maternity Hospital and Critical Care Building. It is that the construction will be completed during 2021-22.

6.4.2 Infection prevention and control (IPC) and environmental cleanliness

We reviewed the arrangements in respect of IPC and environmental cleaning. The overall hospital environment was clean and tidy with good signage displayed to direct patients and visitors to wards and departments.

We observed clean, tidy and organised patient and non-patient areas. Staff demonstrated good knowledge of their role and responsibilities in maintaining a clean and well-maintained environment.

Performance indicators for audits relating to best practice for hand hygiene and environmental cleanliness were widely displayed throughout the Department. There was a range of IPC information available for patients and staff.

We found that patient equipment was clean and in a good state of repair. Staff demonstrated good management of linen, sharps and the disposal of waste. We observed good practice in the use of personal protective equipment and hand hygiene.

Overall we found that IPC management was good. Some opportunities for improvement are required to ensure a toy-cleaning schedule is introduced in all areas, uniform policy is adhered to (staff wearing permeable fabric shoes) and the need for a separate domestic store in Knox Ward.

6.4.3 Safe care practices

We observed staff practices and reviewed documentation to assess if the delivery of care was safe. On our first day of inspection, we observed that patient identification (ID) wristbands were not in place for patients. We were encouraged to find that this was discussed and addressed as part of the ward safety briefs the following day.

On Allen Ward, inspectors noted gaps in the completion of resuscitation equipment records, which are completed daily to ensure resuscitation equipment is readily on the trolley. Additionally, the resuscitation trolley designated for use by the Haemodialysis ward is located in an area away from patients. We were unable to locate evidence of a risk assessment being completed by the Trust resuscitation officer to assess and manage this risk.

Overall, the documentation of Paediatric Early Warning Score (PEWS), to assess and identify a deteriorating patient was well completed throughout all wards visited.

6.4.4 Medicines management

We reviewed the arrangements in place for the management of medicines within the hospital. Inspectors observed good practice in relation to administration of medications, completion of kardexes and management of controlled drugs. The inspection team welcomed the appointment of a senior pharmacist however we were advised by the Trust that pharmacy-staffing levels remained insufficient.

We observed inconsistent recording of refrigerator temperatures and expired medications in refrigerators. Medicines from Paul Ward were stored in the refrigerator in Knox Ward; staff told inspectors that this practice was due to budget codes assigned to services on Knox Ward. We found incorrect segregation and storage of intravenous (IV) infusions, which could increase the risk of an incorrect infusion being selected and administered to a patient.

Inspectors could not find an effective system of assurance relating to antibiotic stewardship within the hospital. The inspection team noted that Hospital Antibiotic Prudent Prescribing Indicators (HAPPI) audits were progressing until November 2018; however, there was no evidence that learning from these audits was actively impacting on care and treatment provided.

Inspectors reported that during discussions with medical staff, they did not demonstrated adequate knowledge and understanding of antibiotic stewardship at ward level.

We reviewed a number of safety incidents and identified that over 20% of incidents in the hospital related to medication. Many staff had not received sufficient training and were not up to date on the appropriate use of Datix. Inappropriate coding of incidents presents a risk whereby potential learning is not identified.

Learning arising from a previous incident relating to IV paracetamol was identified, however despite this learning we found that there was no evidence that action had been taken to implement the learning and we noted that similar incidents continue to occur. We determined that further work is required to ensure learning from incidents is appropriately identified, shared, and used to inform improvement.

We identified transcription errors, in particular patients returning to Clark Clinic from Dublin, London, Birmingham and Manchester.

Inspectors identified an incident were two cephalosporin antibiotics (cefuroxime/cefotaxime) had been mixed up, as they were stored together side by side. While learning to store antibiotics separately was identified, it had not been implemented across all areas.

We determined that further work is required to enhance medicines safety and advised that systems should be implemented which ensure safe practice in the prescription, storage, stewardship of medicines across the spectrum of care and support provided within the hospital.

6.4.5 Safeguarding

We reviewed arrangements for safeguarding of children in accordance with the current regional guidelines. Following our inspection to RBHSC OPD in October 2018, RQIA escalated concerns about the Trusts safeguarding systems and processes and requested submission of an action plan to address issues identified in children's OPD service. As part of the Review of Governance of Outpatients Services in the Belfast Trust, feedback was provided to frontline staff in January 2019 and RQIA met with the Trust in September 2019 to discuss progress in implementing the action plan relating to safeguarding.

During this inspection, we noted progress in relation to systems for safeguarding in the OPD. The OPD manager was aware of the safeguarding and was supportive of staff, sharing information through safety briefs, discussions and posters, as well as maintaining an up to date matrix for safeguarding training

The inspection team found that across the hospital there was good knowledge, understanding and insight into the processes relating to safeguarding and indicated progress since the inspections of OPD services in October 2018.

Some wards in the hospital had progressed with the completion of safeguarding training using their own local matrix and training plan. Good examples of work progressed were identified within the Haematology Ward, which is supported by the social work team in relation to safeguarding systems and practise. Additionally within the ED, good links were established with the social work team, staff were trained to Level 4 and were aware of potential safeguarding concerns should they present in their area of work.

Inspectors found that some of the Trust safeguarding information materials and resources were not appropriately targeted to patients/carers but rather contained information which was targeted and more relevant for staff. We were advised by the Trust of plans to develop improved information materials and plans to provide these throughout the services.

Areas of good practice

Areas of Good Practice were found in relation to ward and department cleanliness and staff infection prevention and control practices. We note significant progress in relation to the embedding of systems for safeguarding across the hospital.

Areas for improvement

Areas for improvement were found in relation to the prescription, storage, stewardship of medicines and safe care practices.

Number of areas for improvement	1

6.6 Is care effective?

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

As part of the inspection, we observed and reviewed the care and treatment provided to patients to ensure that individual care needs were met.

6.5.1 Record keeping

We reviewed clinical records and a range of other documentation to ensure record keeping was completed in line with best practice standards. Wards within the RBHSC have introduced the person centred, assessment, plan of care, evaluation (PACE) framework. This framework was aimed at improving the care planning process, through better more efficient documentation. We noted that delivery of nursing care and treatment was clearly documented and updated within the PACE documentation.

In Allen ward, we were informed that patient care records were not always available for nursing staff to enable them to carry out telephone pre-assessment screening. We found that the list of questions on the screening tool was not sufficient to facilitate meaningful enquiry as to identify all the potential risks and issues relating to the planned care episode. There was no policy, guidance or clinical criteria relating to the decision-making process and input of anaesthetic staff prior to day of surgery. Nursing and medical staff told us of an over reliance on nursing judgement to refer the child for anaesthetic pre-assessment, raising the potential risk for patients undergoing surgery.

We found some examples of poor documentation within medical notes reviewed. For example, pages not labelled with patient details, entries not timed and GMC numbers not stated. In addition, we observed occasions where patient/parent involvement was not routinely documented.

We identified the agreed post procedure process for typing patient discharge notes (at the same time as operation notes) was not fully implemented by medical staff and nursing staff were completing discharge notes to avoid accumulation of unsigned discharge notes and avoid delays in sending information to patient GPs.

6.5.2 Nutrition and hydration

We reviewed arrangements to ensure that patients' nutrition and hydration needs are met. We found that patients had their nutritional needs assessed and there was a good choice of meals, including provision of specialised diets to meet individual patient needs. Meals were served warm, looked appetising and were of an appropriate portion size. Sufficient staffs were available at mealtimes to assist patients and disruption during mealtimes was kept to a minimum.

On observation and review of documentation, we identified that fluids were reasonably well managed with some opportunities for improvement. On the first day of the inspection, we noted variation in how staff completed fluid balance charts and food monitoring sheets used as fluid balance charts. Approximately six fluid balance charts (FBC) were reviewed on each ward during the inspection. Although most well completed, we identified that blood sodium levels, while checked, were not always documented on three FBCs in Paul Ward and one FBC chart in Allen Ward. We identified this to ward staff and were satisfied that it was immediately addressed during inspection.

Areas of good practice

Areas of good practice were found in relation to patients' individual needs being managed. Pain management was good and nutritional needs were met. Fluid management was reasonably well managed and early warning scores were well documented.

Areas for improvement

Areas for improvement were found in relation to the pre-assessment procedures within Allen ward and requirement for effective systems for assuring the quality of medical documentation.

Number of areas for improvement	2

6.6 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.

As part of this inspection, we looked 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.

6.6.1 Person centred care

As part of this inspection, we observed the delivery of care to ensure all patients were treated as individual, with compassion, privacy and dignity.

In areas inspected, we observed staff at all levels treated patients with kindness and respect whilst delivering care and treatment in a compassionate manner.

We reviewed arrangements to ensure that patients' pain was effectively managed. We observed staff engaging well with patients and families and responding in a compassionate, timely and appropriate manner when patients experienced discomfort or emotional distress. Inspectors determined that pain management was good and were encouraged by the use of specialist pain nurse to support staff in caring for children unable to verbalise pain. It was noted that the inspection team did not find any child in pain over the course of the inspection. Patient details and records were stored securely so that confidential and private information was not compromised and privacy maintained. We observe patients privacy and dignity maintained during engagement and treatment by staff.

In order to understand the needs of patients and improve the experience of parents attending the hospital, the 'What Matters to Me' and 'You said, We did' initiative (Pictures 2 and 3) has been introduced across wards and departments. Through these initiatives, children and parents are asked what is important to them when attending the hospital and the RBHSC advises of how they have addressed it. We observed notice boards displaying some parent comments and RBHSC actions.

Picture 2: 'You said, We did' display board

Picture 3: 'What Matters to Me' display board

Intensive Care Unit (PICU), staff carried out an improvement project aimed on the delivery of care to grieving families. This project was in response to issued identified by the hospital bereavement interest group who highlighted the need to align the children's hospice values with the hospital setting. Actions were taken to improve the PICU environment; creating a pyjama fund, child friendly bedding, and multi-sensory lighting. Memory making was a central focus of the project and memory boxes containing a clay impression kit for hand and feet imprints and teddy bears are given to parents (Picture 4).

Picture 4: PICU Memory Box

We were informed that parents reacted positively to environmental improvements and memory making boxes. We noted this as an improvement project that has potential to continue to provide some support to families experiencing bereavement.

6.6.2. Communication

During the inspection, we listened to how staff engaged with patients, relatives and carers and promoted high quality care and positive patient experience. We observed warm and welcoming interactions between staff, patient's, families and carers.

We heard many examples of excellent communication from staff who gave information to children and advice to relatives and carers in a way that was easily understood.

We heard that staff use the interpreting service to support those families were English was not their first language and staff engage well with families.

6.6.3 Patient and relative feedback

As part of the inspection, we spoke to children and their parents/carers to obtain feedback on their experience of attending RBHSC.

Throughout our inspection, we observed staff at all levels treating patients, families and carers with kindness and respect whilst delivering care and treatment. Feedback from parents/carers about care their child received/was receiving was consistently good. Some comments included good communication before and during admission, staff taking time to ensure children feel supported and good supportive links between school/hospital teachers.
Whilst feedback about the quality of care delivered on the ward was positive overall, parents/carers did raise a number of practical issues. These included a lack of shower facilities in Paul Ward and a general lack of overnight facilities for parents that would have potential to further improve the experience of families of children within the hospital.

Areas of good practice

We found that staff at all levels treated patients with kindness and respect whilst delivering care. We observed many warm interactions between staff and families and carers. Feedback from parents/carers about the care their child received/was receiving was consistently good.

Areas for improvement

No areas for improvement were identified during this inspection in relation to compassionate care.

Number of areas for improvement	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the trust senior management team as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The trust should confirm that these actions have been completed and return the completed QIP for assessment by the inspector.

Quality Improvement Plan

The Trust must ensure the following findings are addressed:

Area for improvement 1 **Ref**: Standard 4.1 Criteria 4.3 (a) Standard 5.1 Criteria 5.3 (e & f) **Stated:** First Time **To be completed by:** 1 July 2019	Development and implementation of an overarching 'Patient Safety System' which is multidisciplinary in ethos and in practice. This should include audit, targeted quality improvement work, incident management systems and should be part of the overall assurance framework for the Directorate. This system should be directed and informed by the monthly governance meetings and contribute to Trust assurances in respect of the safety and quality of care within the hospital. **Ref:** 6.3.3
	Response by the Trust detailing the actions taken: The Child Health and Northern Ireland Specialist Transport and Retrieval (NISTAR) Division has an overarching Patient Safety System in place which is multidisciplinary. The multidisciplinary team (MDT) consists of medical, nursing, quality lead, management and administration staff from each area in the Division. It includes the following. Daily team safety briefings for sharing learning & effective communication. Daily safety Quality Management System (QMS) with the MDT. This will proactively prioritises governance issues in real time. (this commenced in October 2020). Weekly Live Governance which includes operational areas providing updates on assurance, governance and review of any issues. Weekly Child Health Incident Review meeting (CHIP). It reviews the previous week's incidents reported by operational teams. It is chaired by the Quality Manager with medical, nursing and pharmacy representatives from the operational areas. Weekly BHSCT governance call which is led by the medical Directors office to raise any potential high-risk issues and ensure appropriate action. Monthly Clinical Director meetings with representatives from the MDT and a focus on patient safety. Monthly audit meeting to discuss ongoing and future audits to enhance patient care. Monthly Morbidity and Mortality MDT meetings. Monthly Divisional Nurse assurance meetings with operational areas to provide oversight and assurance about nursing related issues and practice. Monthly RBHSC Sisters meetings as well as local team meetings.

	Divisional Governance meetings; the MDT reviewing trends with a focus on learning. Quarterly Specialist Hospital and Women's Health Directorate (SHWH) Assurance meeting held with Director to provide the assurance of our services delivered. The Division continues to make good use of Schwartz rounds and has a rolling programme to optimise use of this valuable tool. Staff debriefing mechanisms are in place for particular difficult clinical scenarios to provide supportive learning. All these forums provide a multidisciplinary approach at all levels to identify any safety concerns proactively look at ways of improving the service delivered by an informed and innovative workforce
Area for improvement 2 **Ref**: Standard 4.1 Criteria 4.3 (b) **Stated:** First Time **To be completed by:** 1 July 2019	The trust should identify and define the function and purpose of all 'End of Ward or 'Part of Ward' services being delivered. The Trust should ensure robust governance and assurance systems and appropriate oversight of clinical staff working in these 'End of Ward' and specialist nurse led services. **Ref:** 6.3.4
	Response by the Trust detailing the actions taken: Currently the specialist nurses across the Child Health and NISTAR Division have a clear line management and reporting structure. This is to the Assistant Service Manager (ASM) who is part of the MDT. They have regular meetings with the ASM which includes the governance arrangements described in Improvement 1. The space used at the end of the wards by the nurse specialists is not managed by the ward sister of that area but by the ASM. The Divisional Nurse in conjunction with ASM and MDT continues to work with the specialist nurses. This includes reviewing patient outcome reviews, governance, supervision of clinical practice and ongoing personal and development plans.
Area for Improvement 3 **Ref**: Standard 5.1 Criteria 5.3.2 (c) **Stated:** First Time **To be completed by:** 1 July 2019	The trust should ensure that effective reporting systems are in place to identify, collate, analyse and learn from all adverse incidents, and near misses and share all relevant learning across the full range of professional groups involved in delivering care within the hospital. **Ref:** 6.3.5
	Response by the Trust detailing the actions taken: As included in Improvement point 1 – Child Health & NISTAR Division has clear processes already in place to identify, collate, analyse and learn from all adverse incidents and near misses. These are MDT in structure.

	This includes the weekly CHIP, live governance meetings and the QMS daily meeting launched in October 2020. Monthly incident reports are sent to the Service Managers and Clinical Directors to action any outstanding unapproved incidents and outstanding issues. Action plans for incidents, including Serious Adverse, are discussed at with the MDT. All incident action plans with staff responsibilities and timeframes are discussed at the governance and SHWH Assurance meeting for updates on same. Learning is shared with staff at the meetings described above and Shared Learning letters. These are shared with the service management teams to disseminate and discuss with their operational teams. Hot debriefs of incidents take place with the MDT and this information is also shared with all those involved. Weekly BHSCT governance call, which is led by the medical Directors office, takes place to raise any potential high risk issues and ensure appropriate action. On the incident management system, Datix, the incident reporter can now also request feedback on the action taken. All medical staff can attend Clinical Director monthly meeting monthly morbidity and mortality meeting where incidents and associated learning is discussed. The Clinical Directors are part of Child Health and NISTAR Senior Management team and attend meeting as described in Improvement 1.
Area for Improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 1 July 2019	The Trust should implement systems to assure the delivery of safe practice in the prescription, storage, stewardship of medicines across the range of services provided within the hospital. This should ensure full compliance with current medicines legislation. **Ref:** 6.4.4
	Response by the Trust detailing the actions taken: The majority of wards and clinical areas in RBHSC now have a clinical pharmacist and medicines reconciliation completed. Further work and funding is required to fully develop this across the hospital. Work is ongoing with the pharmacy department in BHSCT and the Commissioners of the services. Each clinical area has a MDT safety brief and safety checks. Each clinical area has its own identified storage area for medication. Staff training is provided across the full range of medicines management as per their designated role and responsibilities. Medication errors are reviewed as part of Incident management and Live Governance MDT meetings with appropriate remedial action taken as required.

	Medication errors are also discussed weekly at the CHIP meeting and there is a pharmacist in attendance. All medication incidents, including coding of the incident within BHSCT are reviewed by the Pharmacy governance team. Preliminary meetings held to progress antimicrobial stewardship throughout RBHSC. This is MDT and led by Paediatric Infectious Diseases Consultant in conjunction with clinical unit staff and pharmacy colleagues.
Area for Improvement 5 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 1 July 2019	The process and systems for the pre-assessment/ telephone pre-assessment within Knox ward should be reviewed, strengthened and clearly documented. These systems should include; ensuring staff have access to all required patient information and documentation; improvements to the tool screening tool to ensure it identifies all the potential risks and issues and clear guidance to support decision-making process around anaesthetic pre-assessment. **Ref:** 6.5.1
	Response by the Trust detailing the actions taken: There is now a system in place to ensure the clinical notes are available in order to carry out pre-assessment clinics. Formalised telephone and/or face to face triage in place for all elective surgical patients. The pre-assessment documentation has been reviewed by the MDT and audited. This includes a flowchart to ensure appropriate referral and support to the anaesthetic and/or medical teams to assist in pre-assessment decision making.
Area for Improvement 6 **Ref**: Standard 8.1 Criteria 8.3 (h) **Stated:** First Time **To be completed by:** 1 July 2019	The Trust should implement systems which provide assurance of the quality of medical records as part of its continual audit programme. These systems should be used to drive improvements in the quality of medical documentation. **Ref:** 6.5.1
	Response by the Trust detailing the actions taken: RBHSC will implement the audit system in relation to the review of the quality of medical records and take appropriate actions.

It should be noted work ongoing is restricted with Covid-19 impact on the services in RBHSC, BHSCT

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