Care Quality Commission

Wrightington, Wigan and Leigh NHS Foundation Trust

Royal Albert Edward Infirmary

Quality Report

Wigan Lane, Wigan
WN1 2NN
Tel: 01942 244000
Website: www.wwl.nhs.uk

Date of inspection visit: 17 March 2017
Date of publication: 14/09/2017

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Good
Services for children and young people	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Albert Edward Infirmary is a large district general hospital operated by Wrightington, Wigan and Leigh NHS Foundation Trust. It provides a full range of hospital services including emergency care, critical care, general medicine (including elderly care), surgery, neonatal care, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services. The hospital has 513 beds.

Urgent and emergency services and children and young people's services at Royal Albert Edward Infirmary were previously inspected in December 2015. Urgent and emergency services were rated as 'good' and children and young people's services were rated as 'requires improvement'.

In March 2017, we carried out an unannounced inspection of these services to review specific areas of care including the assessment and observation of patients, record keeping, pathways of care for discharging or transferring patients, staff training and staffing levels.

The inspection was in response to concerns that were raised about the safety of services provided to patients. The inspection therefore focused solely on the safety of services provided. We inspected the hospital during the evening/ night of 17 March 2017, visiting the following areas:

- Paediatric Emergency Care Centre (PECC)
- Emergency Care Centre (ECC)
- Rainbow Ward

We found that these services required improvement for safety. This was because the systems and processes for recognising risks and escalating the deteriorating patient were not always adhered to, records were not always completed correctly and compliance levels in some areas of training, such as safeguarding level three, were lower than the trust target.

Our key findings were as follows:

- Records were not always completed fully by medical and nursing staff. This meant there was limited evidence of the care provided to patients.
- Despite tools being available to help staff manage risks to patients, they were not always used effectively. For example, in some records we reviewed we saw no evidence of clinical observations, early warning scores and risk assessments. We also had concerns that some of the guidance relating to managing risk was unclear. For example, one piece of guidance instructed staff to complete 'routine' observations, without clarifying the specific frequency.
- Mandatory training figures for staff did not always reach the trust target of 95%. Training for safeguarding was particularly low. This posed a risk that staff may not have the necessary training to enable them to care for patients appropriately.
- Dispensers storing sanitising gel were empty in the main reception area in the emergency care centre. This limited people's ability to clean their hands effectively prior to entering the department.
- A room in the emergency care centre storing major incident and chemical decontamination equipment was also used occasionally to take blood samples from patients. The room was a less than ideal environment with large items of equipment next to the trolley where patients sat to provide their samples.
- Duty of candour was not fully documented in the investigation report following the never event on Rainbow ward.
- Appropriate action was not always taken following completion of the Paediatric Early Warning Score (PEWS) on Rainbow ward.

Summary of findings

However:

- Following our inspection in December 2015, the trust had improved the levels of training for nurses on Rainbow ward, with higher compliance in advanced paediatric life support and tracheostomy care.
- Staffing levels on Rainbow ward were also improved, with greater numbers of staff available to care for children at all times.
- Staff in the Emergency Care Centre were able to explain their actions during major incidents or incidents involving hazardous substances.

In areas of poor practice the trust needs to make improvements.

Importantly, the trust must:

- Ensure staff complete mandatory safeguarding children training appropriate to their role.
- Ensure staff complete other mandatory training to maintain compliance in line with the trust target.
- Ensure that tools to manage risk are used and recorded such as completing risk assessments and observations and taking appropriate action when triggering Paediatric Early Warning Scores (PEWS).
- Ensure that patient records are accurate and complete.

In addition the trust should:

In relation to children and young people services:

- Ensure duty of candour is documented following a notifiable safety incident.
- Ensure cleaning schedules are consistently completed in all areas.
- Ensure the expiry date is legible on all controlled drugs.
- Ensure the medicine fridge thermometer is reset in line with trust policy and action taken is documented when the fridge temperature deviates from the acceptable range.
- Ensure the refrigerator in the milk room is available and fit for use.
- Ensure current guidelines for the management of paediatric sepsis are available for staff.

In relation to urgent and emergency services:

- Ensure trust guidance is consistent throughout all departments in relation to the use of early warning scores, clinical observations and general monitoring of patients, and that where required, categories and frequency of monitoring is stipulated to ensure clarity.
- Ensure that all staff use the same guidance relating to the frequency of observations
- Ensure that sanitising gel is available in all dispensers
- Review the suitability of the room used to store major incident equipment in relation to taking blood samples from patients
- The trust should review the entrance and exit door to the paediatric emergency care centre with a view to ensuring the risk of children or young people exiting the department is as low as practicable.
- Consider amending the checklists used on resuscitation trolleys to ensure any action to replace missing items can be documented to avoid potential confusion.
- Consider introducing checklists to record that defibrillators have been checked rather than relying on printed strips stored in no particular order.
- Obtain assurance and ensure that staff involved in assessing patients are aware of, or appropriately prompted to consider female genital mutilation
- Ensure that guidance about conditions requiring senior medical review covers occasions when consultants are not on site and available only on an on call basis.

Summary of findings

- Ensure that the care pathway for caring for patients with a blood borne virus is up to date and that the latest version is displayed on the relevant noticeboard in the emergency care centre.
- Only store equipment in appropriate packaging and remove equipment that is not stored in this way.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	• Records were not always completed fully by medical and nursing staff. • Despite tools being available to help staff manage risks to patients, they were not always used effectively. For example, in records we reviewed we saw no evidence of clinical observations, early warning scores and risk assessments in some records. We also had concerns that some of the guidance relating to managing risk was unclear. • Mandatory training figures for staff did not always reach the trust target of 95%. Training for safeguarding was particularly low. • Dispensers storing sanitising gel were empty in the main reception area. • A room storing major incident equipment was also being used to take blood samples from patients. The room was a less than ideal environment. However • There was a culture of reporting and learning from incidents amongst staff. • Medicines were managed, stored and checked correctly with automatic systems in place. • Staff were 100% compliant in mandatory training topics including anti-fraud awareness, emergency planning, conflict management and dementia training. • Major incident information was clearly displayed for staff, who were supported by a trust policy. • All the areas we reviewed were visibly clean and tidy. Cleaning schedules were used and adhered to. • The right equipment was available for staff caring for patients.
Services for children and young people	Requires improvement 	• There was one never event reported by the trust on Rainbow ward between 1 March 2016 and 31 March 2017. • Duty of candour was not fully documented in the never event investigation report.

Summary of findings

- Compliance rates for safeguarding children level three was 77.8% for paediatric medical staff and 28.6% for registered paediatric nurses on Rainbow ward.
- Records we reviewed showed that four out of five records did not have appropriate actions taken on triggering Paediatric Early Warning Score (PEWS).

However,

- Staff knew how to report incidents and lessons learned were shared with staff
- The ward was visibly clean and staff adhered to current infection prevention and control guidelines.
- Emergency resuscitation equipment and safety testing was in place, and a bedrails assessment was completed on admission.
- Safeguarding policies and procedures were in place across the trust. Staff we spoke with were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- The nursing staff ratio on Rainbow ward was a maximum of 1:5 for both general paediatric patients and paediatric surgical patients. Between 1 January and 31 March 2017, this had been achieved on all but four shifts (98.5%).

Royal Albert Edward Infirmary

Detailed findings

Services we looked at
Urgent and emergency services; Services for children and young people

Detailed findings

Contents

Background to Royal Albert Edward Infirmary

The Royal Albert Edward Infirmary (RAEI) is the main district general hospital site, located in central Wigan that hosts the Emergency Care Centre, Paediatric Emergency Care Centre and Rainbow Ward (a ward for children and young people aged 0-16 years).

There are 513 beds in this hospital which is operated by the Wrightington Wigan and Leigh NHS Foundation Trust. The trust serves a population of 320,000 local people.

Our inspection team

Our inspection was led by:

Inspection Manager: Nicola Kemp, Care Quality Commission

The team included an inspection manager, two CQC inspectors and a consultant paediatrician specialist advisor.

How we carried out this inspection

In response to concerns about the care provided to people in urgent and emergency care and care for children and young people, we completed an unannounced inspection to find out whether the services being provided were safe.

The inspection team inspected the following core services at the Royal Albert Edward Infirmary.

- Urgent and Emergency
- Children and Young People

Prior to the focused inspection, we reviewed a range of information we had about these services. During our inspection we interviewed staff and spoke with patients from Rainbow ward and the Emergency Care Centres. We observed how people were being cared for and reviewed patients' records of personal care and treatment. Following the inspection we reviewed a range of information (data) sent to us by the trust.

Detailed findings

Facts and data about Royal Albert Edward Infirmary

Royal Albert Edward Infirmary in Wigan (sometimes referred to as Wigan Infirmary) is a district general hospital with 513 beds which is situated close to Wigan town centre.

It is managed by the Wrightington, Wigan and Leigh NHS Foundation Trust, which is a major acute trust, primarily serving a population of around 320,000 people in and around Wigan and Leigh.

The trust has four main sites: Royal Albert Edward Infirmary, specialising in Accident and Emergency, general medicine, surgery and maternity, Leigh Infirmary, which provides elderly and outpatient services, Wrightington Hospital, specialising in orthopaedic surgery and rheumatology and Thomas Linacre Centre, which houses the trust's main outpatient department.

The trust manages a budget of over £220 million each year.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	N/A	N/A	N/A	N/A	Good
Services for children and young people	Requires improvement	N/A	N/A	N/A	N/A	Requires improvement
Overall	Requires improvement	N/A	N/A	N/A	N/A	Requires improvement

Notes

Urgent and emergency services

Safe	Requires improvement
Overall	Good

Information about the service

The Royal Albert and Edward Infirmary is a district general hospital, providing emergency care for adults and children, 24 hours a day, seven days a week, all year round.

The hospital has an Emergency Care Centre (ECC), which cares for adults at all times and a Paediatric Emergency Care Centre (PECC), which cares for children between 7am and 1am each day.

The main ECC has a resuscitation area with five bays (one of which is suitable for trauma and one for children), a 'majors' area with 16 cubicles, which provides care for those with serious illness or injury and a 'minors' area, which has eight cubicles.

Additionally there is a clinical decision unit with 11 beds, used for patients ready to be discharged but awaiting minor treatment or test results. There is also an x-ray department, rooms for eye or ear, nose and throat treatment, two other treatment rooms and a quiet room for relatives away from the main waiting area.

In the PECC, children and young people up to the age of 16 years receive care and treatment.

The PECC has one waiting area, six cubicles, a triage and private examination room and a high dependency treatment room, which enables staff to provide a higher level of care for seriously unwell children if required.

We arrived to undertake an unannounced inspection of the ECC and PECC at 7pm on the evening of 17 March 2017.

During our inspection we spoke with 12 staff members, including nurses, doctors, bed managers and site managers. We also spoke with four patients and reviewed 18 patient records. Before and after the inspection we reviewed information provided by the trust.

Summary of findings

We rated urgent and emergency services as requires improvement. This is because:

- Records were not always completed fully by medical and nursing staff. This meant there was limited evidence of the care provided to patients.
- Despite tools being available to help staff manage risks to patients, they were not always used effectively. For example, in records we reviewed we saw no evidence of clinical observations, early warning scores and risk assessments in some records. We also had concerns that some of the guidance relating to managing risk was unclear. For example, one piece of guidance instructed staff to complete 'routine' observations, with no clarification to confirm the actual frequency of observations required.
- Mandatory training figures for staff did not always reach the trust target of 95%. Training for safeguarding was particularly low. This posed a risk that staff may not have the necessary training to enable them to care for patients effectively.
- Dispensers storing sanitising gel were empty in the main reception area. This limited people's ability to clean their hands effectively prior to entering the department.
- A room storing major incident equipment was occasionally used to take blood samples from patients. The room was a less than ideal environment which large items of equipment next to the trolley where patients sat to provide their blood samples.

However:

- There was a culture of reporting and learning from incidents amongst staff in the department.

Urgent and emergency services

- Medicines were managed, stored and checked correctly with automatic systems in place to help reduce the risk of unauthorised entry and incorrect selection.
- Staff were 100% compliant in mandatory training topics including anti-fraud awareness, emergency planning, conflict management and dementia training.
- Major incident information was clearly displayed for staff, who were supported by a trust policy. Senior nurses we spoke with were able to explain the process of caring for patients involved in a major incident or with possible blood borne viruses.
- All the areas we reviewed were visibly clean and tidy. Cleaning schedules were used and adhered to on a daily basis in all areas.
- The right equipment was available for staff caring for patients. The majority of equipment was stored and checked correctly. Where we found one type of paediatric equipment not stored correctly, staff explained the correct way to store it and took steps to ensure the issue was rectified.

Are urgent and emergency services safe?

Requires improvement

Incidents

- During our previous inspection and when we visited again this time, we saw there was a culture of reporting and learning from incidents amongst staff in the department.
- Incidents were reported using an electronic web based system. Automatic emails were issued to staff to acknowledge receipt following submission.
- Between March 2016 and March 2017, the Emergency Care Centre (ECC) staff reported 1034 incidents. Of these, 1008 were categorised as 'no or minor harm' and 19 were categorised as requiring short term treatment (not necessarily caused by the incident). Six incidents were categorised as causing death or long term/ permanent harm. Of these, one related to the care provided by a separate NHS trust, and the other incidents related to patient deaths following discharge, missed opportunities to diagnose and a patient passing away in the department.
- During the same period, the Paediatric Emergency Care Centre (PECC) reported 34 incidents, 33 of which were categorised as 'no or minor harm' or requiring short term treatment. The remaining incident related to the death of a child in the department following two previous attendances resulting in discharge. A full investigation was in progress at the time of our inspection and managers were liaising with relevant authorities to ensure lessons were learned and changes made where required.
- No 'never events' had occurred in either the ECC or the PECC during this period. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff understood the types of incident they needed to report and gave examples of incidents they had reported, including medicine errors and information governance breaches.

- Designated senior staff investigated incidents and written feedback was sent to the reporting staff member when complete. Learning could be shared with other staff in daily debriefs if required.
- Serious incidents were investigated using root cause analysis within a time limit of 60 days. For very serious incidents, independent reviews were commissioned by the trust to help make sure investigations were unbiased. Where learning needed to be shared more widely we saw that the trust took steps to do this, listing actions on investigation reports which were monitored by local commissioners.
- Debriefs were arranged with staff following particularly distressing incidents, which staff told us felt supportive.
- Duty of candour was considered for serious incidents. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw prompts on report templates to remind staff to consider duty of candour and confirm whether or not it had been implemented.
- Mortality and morbidity was discussed at monthly clinical governance meetings. Minutes showed that individual cases were discussed by senior clinical staff and trust managers with an emphasis on learning.

Cleanliness, infection control and hygiene

- During the previous inspection we saw that areas of the departments were visibly clean and tidy, and that cleaning records were well kept and up to date.
- We saw that this remained the case when we undertook this inspection. All the areas we reviewed in the ECC and PECC were visibly clean and tidy. However, we saw three empty sanitising gel dispensers in the ECC reception area, which limited the opportunity for staff and visitors to sanitise their hands.
- Staff used different bins to ensure clinical waste was separated and disposed of appropriately.
- Cleaning staff were based in both departments between 8am and 1pm. After this, general cleaning staff based within the hospital were called to attend if needed, using the bleep system. However, nursing staff told us they usually cleaned spillages themselves and we saw this during our inspection.
- Cleaning records showed that cleaning took place daily in all areas, including cubicles, nurses' station, equipment, sluices, work tops and trolleys. Staff initials were used to identify who had cleaned items. These staff also checked and replaced linen stocks as part of their role.
- Audits helped monitor adherence to good practice for hand hygiene. In April and May 2016, the results showed that staff were 89% compliant with good hand hygiene practice and from June 2016 through to March 2017, compliance was consistently 100%.

Environment and equipment

- The PECC and ECC were located adjacent to one another at the front of the hospital. The main doors led to reception areas, with secure access to treatment areas.
- During our previous inspection we saw that the department was well maintained, clear of clutter or hazards and provided a suitable environment for treating patients. During this inspection we saw that this remained the case. Patients were cared for in bays or in a treatment room, depending upon their needs.
- The PECC was secured by a locked gate to help prevent children leaving the department unnoticed. During our last inspection, we noted that the security of this gate was limited, with only a slide latch to secure it closed. During this inspection we saw that this remained the case and witnessed a young person under the influence of alcohol leave the department and run onto a main thoroughfare. Whilst security staff were aware of and able to escort the patient back to a cubicle, we remained concerned that the level of security provided by the gate may not be adequate to consistently keep children and young people safe whilst in the department.
- Staff had access to a range of equipment in an environment, which was tailor made for providing emergency care.
- We reviewed equipment in the resuscitation area of the ECC and the high dependency area of the PECC. Here we found equipment was stored in an orderly, accessible way in clearly labelled trolley drawers, divided into airways, breathing and circulation.
- All the equipment we reviewed was within expiry date and appropriately packaged (for example, sterilised), except for paediatric face masks in the paediatric bay of the adult resuscitation area. Here we found five masks which were unpackaged in a drawer of the resuscitation trolley. When we asked nurses about them, they said

they did not know why they were unpackaged and would ordinarily use other masks which were packaged. They informed us they would notify a manager to ensure the problem was rectified.

- Nurses said equipment was checked daily, except for defibrillators, which were checked weekly. Records in the ECC confirmed what we were told. We saw that staff noted missing items, but we saw no record of action taken to replace them. However, we did see that trolleys had useful checklists to inform staff what equipment should be present in each drawer. This ensured staff could clearly identify missing items and take action to replace them if necessary.
- In the PECC high dependency room, although the checklists were present, we saw no written records to confirm that defibrillator checks were complete. Instead, paper strips of printed test results were present in no particular order. When we asked nursing staff about this, they confirmed no other written records of checks existed. We saw strips dating back to 2015, but there were not enough strips to evidence regular checks were undertaken since then. In light of the fact that we had difficulty locating any recent strips (dated 2017), we were concerned that staff could not be assured that the checks were completed as regularly as required.

Medicines

- A range of medicines and controlled drugs were stored and used by staff in the department. There were appropriate trust policies in place to support staff responsible for handling them.
- Some medicines and drugs prescribed by medical staff and others were given by non-medical prescribers, such as nurse practitioners, using patient group directives (PGDs). (PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available). We checked a sample of PGDs and found they were up to date and authorised appropriately.
- All the medicines and drugs that we reviewed were within expiry date and stored correctly.
- In the resuscitation area, medicines were securely stored in a cabinet inside a locked room which was linked to an electronic system. Finger print recognition was used to authorise entry.
- Controlled drugs were also stored securely and in accordance with legislation in the minors, majors and resuscitation areas. A paper drug register was used to record use. Nurses were able to explain how controlled drugs were issued, which included recording the date, authorising person and two signatures confirming who removed and who cross-checked removal. Daily checks were done (including weekends) to ensure stock levels were correct and corresponded with the entries on the register.
- Each month, pharmacy staff audited controlled drug stock and the register to further check that practice for issuing and recording stock was correct. We saw evidence of these checks in the register. We also saw audits completed for medicines stored in fridges in the PECC, which showed that 100% of fridges were locked when not in use and that staff understood trust medicine and controlled drug policies.
- Nurses told us that any errors or anomalies in medicine stock levels or register entries were reported as incidents and shift leaders were informed. Meetings took place every two months to review these incidents or the standard operating procedures relating to the issue or use of medicines or controlled drugs.
- Medicines requiring storage at low temperature were kept in locked fridges. Each day staff noted minimum and maximum temperatures recorded by thermometers over the previous 24 hours along with actual fridge and room temperatures overall. This helped make sure that temperatures did not fall out of range, which otherwise could lower the efficacy of these medicines.
- A medicine management link nurse worked in the department, enabling staff to obtain further information about medicines if required.
- Pharmacy staff restocked medicines and drugs each day. The electronic medicine storage system recorded medicines used and automatically informed pharmacists about which medicines required replenishment.
- To make sure stocks were rotated, staff marked medicines approaching expiry date to help make sure they were used first.
- A coloured bin was used to clearly identify where staff placed used or expired drugs requiring incineration.

Records

- Patient records were both paper and electronic. To ensure that all details were captured electronically, any paper records were scanned onto a patient's electronic file following treatment.

Urgent and emergency services

- During our last inspection we reviewed records and found that they were clear, legible and had regular entries but some details such as early warning scores were not always included.
- As part of this inspection, we reviewed 18 records, 12 of which were for children. We assessed whether records were legible and contained the correct details, including staff identification, patient risk assessments, appropriate safeguarding referrals, pain assessments and plan of action.
- From reviewing the records, we found that whilst some information was included, other important details were missing. Our findings supported our previous concerns that documentation was not always completed in line with guidance from NHS Professionals and the Nursing and Midwifery Council. NHS Professionals guidance (January 2016) states that record keeping 'is essential to the provision of safe and effective care', and that 'good record keeping shows how decisions related to patient care were made while poor record keeping increases the risk of harm when making decisions'.
- In 11 records, signatures, printed names or designation of clinical staff were missing. This made it difficult to identify the people providing care for patients.
- In five of the 12 records belonging to children, safeguarding risk assessments were not completed. Staff told us risk assessments should be completed for all children. This was recorded as an issue on the department risk register, with action to mitigate the risk which involved increasing paediatric nurse staffing overnight.
- In adult records we saw that risk assessments for falls, skin integrity and possible dementia were all completed.
- One record contained no details to justify why a child was being discharged.
- Six records contained no documented plan of action in relation to care or treatment and eight records had no evidence of either observations being completed or the frequency of observations determined.
- Two out of 12 children's records reviewed had no paediatric early warning score (PEWS) entered. Another record had a PEWS score which was unreadable following scanning and another had a PEWS score entered as zero, despite there being no observations evident from which the score could be determined.

Safeguarding

- Staff used a trust policy to support them with safeguarding duties.
- Staff were trained to assess patients of all ages for potential safeguarding issues. They completed different levels of training based upon the level of contact they had with children and their safeguarding responsibilities. For example nurses and doctors completed level three training.
- During our last inspection we found that overall, 96.5% of nursing staff were compliant with level three safeguarding training. However, during this inspection we found levels of compliance had fallen. Only 37% of ECC nurses and 58% of paediatric nurses were compliant. For ECC medical staff the compliance rate was 24%. Managers explained that this was due to a change in training and reassessment of the levels required for different staff rather than staff not having received any training. Additionally, training courses for level three safeguarding were scheduled to ensure staff could attend training. By scheduling ahead the trust hoped to improve compliance to 96% by July 2017.
- Contact telephone numbers were available for staff to escalate concerns both within and outside of normal working hours. For example, during the day staff contacted the hospital safeguarding team and outside of office hours, they contacted the local authority directly.
- Staff were able to describe types of issues which they felt would constitute a concern, such as multiple attendances for traumatic injury.
- Staff reported safeguarding concerns via an electronic system and described the process as simple and efficient.
- Since 2015 organisations have had a legal duty to report incidents of female genital mutilation (FGM). When we asked the trust they provided evidence that safeguarding training included learning about FGM. However, when we asked two nurses working in the PECC whether they had completed training to help them identify cases of FGM, one said there was no specific training and the other was uncertain. We were concerned that being unsure about whether training had taken place posed a risk that staff had not retained important information. We also noted that no formal prompts were in place during initial assessment to remind staff to explore this with patients, where appropriate. Whilst this is not a requirement of the

universally used Manchester Triage System at this time, we remained concerned that the two issues together posed a greater risk that staff may not always identify possible cases of FGM.

Mandatory training

- All staff completed mandatory training, which was a requirement of their role. Training was overseen by a practice development nurse based in the department.
- Training topics included information governance, medical device training, fire safety, health and safety, safeguarding, resuscitation and moving and handling training.
- Figures for April 2017 showed that, overall, registered nurses in the ECC were 94% compliant and medical staff were 63% compliant with required training. In the PECC, staff (both nursing and medical staff) were 97% compliant. There was 100% compliance in a number of topics, including anti-fraud awareness, emergency planning, conflict management and dementia training. However, following previously adequate compliance, we saw that this had fallen in areas, including level three child safeguarding training (see under 'Safeguarding' subheading) and basic resuscitation (previously over 95% compliance, but since fallen to 80% for ECC nurses and 52% for ECC medical staff.
- Despite low compliance in some areas, staff we spoke with were able to tell us whether they were up to date with training and navigated the system to find out when training was due with ease. The system identified which training they had started and not yet finished, which they had completed and which training was due within the next 60 days.
- Email reminders were sent to staff due to complete training to prompt them to book sessions.

Assessing and responding to patient risk

- During our last inspection in December 2015, we saw that observations were regularly recorded, early warning score (EWS) and triage systems were in place and used routinely and sepsis pathways helped staff identify and recognise these cases in particular. The Manchester Triage System (MTS) tool aims to reduce risk by triaging patients and seeing them in order of clinical priority, rather than order of attendance. The EWS system uses clinical observations to produce an overall score to indicate how unwell a patient may be. To accurately calculate a EWS, a range of clinical observations should be completed. If some observations are not completed, the score may be inaccurate.
- However, we chose to inspect urgent and emergency services again because we had concerns about the way potential risks were being managed. This was because we had received intelligence about particular incidents since our previous inspection, and after discussions with senior trust managers we were not fully assured that systems and processes to assess and respond to risks were being used as effectively as they should be.
- During our latest inspection we saw that these systems and processes were still in place. Additionally, senior nurses described the use of a rapid assessment and treatment model when triaging patients, which allowed them to initiate tests and treatment at the point of triage, rather than waiting for a doctor to review them after the triage process was complete. For example, triage nurses could order some medical tests, such as x-rays or blood tests, which helped initiate investigations. Furthermore, between 12pm and 8pm a senior doctor was assigned to the triage area to assist nurses in initiating tests and treatment as early as possible.
- We saw that observations charts used a traffic light system to help staff identify whether they were outside of normal range and by how far. For example, observations that were very far out of range were categorised as red. These in turn linked with the early warning score system.
- In December 2016, a paediatric early warning score (PEWS) system was introduced specifically for children following a serious incident in the PECC. At the time the trust told us that PEWS scores would be calculated where relevant for children attending the departments.
- Despite this, we identified that, although these systems were in place they were not always used when they should have been. For example, four of twelve paediatric records we reviewed did not have a PEWS score calculated and in another record we saw a PEWS score calculated, but no record of any observations forming the basis for this score.
- Additionally policies and guidance did not specify the frequency of repeat observations, which left us concerned that staff may not fully understand the process. For example, the guidance stated that children categorised as 'green', should have 'routine'

observations'. Whilst a senior nurse was able to confirm that 'routine' meant 'every four hours', the document did not clarify this, which left us concerned that the guidance was open to interpretation and that new or inexperienced members of staff may not know how frequently to complete them.

- We saw that the condition of one child in the PECC had been categorised as 'white', but this colour was not explained in the guidance shown to us during the inspection. Whilst an established nurse was confident this meant that all observations were within normal range, we were concerned that new or less experienced nurses may not be as familiar. Shortly after our inspection the trust sent us a different document which did explain this. Not explaining this in all written guidance made the process of taking and repeating observations less robust and left staff and patients open to risk because of the lack of clarity.
- We had been informed that following the introduction of the PEWS system, audits were completed nightly to help make sure staff used the system and calculated scores correctly. Senior nurses told us they were not aware of any audits undertaken to monitor performance in this area. However, the trust sent us an example of a monthly audit for March 2017, which reviewed 306 children's records. The results showed that 240 of these children were seen in the department during PECC operating hours and all but two records had PEWS recorded. When the PECC closed, compliance dropped to 77% (15 out of 66 records had no PEWS recorded). Whilst we noted that based on average figures for March 17, only two children attended the ECC when the PECC was closed, we saw that the trust was taking action to improve results. An action plan was being implemented at the time of our inspection to raise awareness of the need to calculate PEWS scores and continue with audits to monitor compliance overall.
- To help make sure trained staff were always available to care for children, despite the PECC closing between 1am and 7am each day, the trust were working to introduce a paediatric nurse 24 hours a day. Consultation with existing staff and recruitment were in in progress to ensure this could be implemented. It was expected that 24 hour paediatric nurse cover would be provided by May 2017.
- Recent changes had been made to improve care for children with symptoms of sepsis (a life-threatening illness caused by the body's response to an infection). The changes included a new screening tool to help staff identify possible cases of sepsis. We saw evidence that training had been given to nurses and a staff member acted as a sepsis lead, which ensured there was a designated contact should other staff have any queries. Minutes of a meeting held in February 2017 showed that staff felt care for children with sepsis was a priority and these changes were being implemented as a result.
- Since December 2016, senior managers had worked to place greater emphasis on ensuring that consultants reviewed patients suffering with particular problems prior to discharge. Minutes of meetings in the department showed that senior medical staff had discussed this and written a standard operating procedure to help embed the process. We also saw written guidance for staff to use as a reference if needed and a senior nurse told us the guidance document had been cascaded to staff during morning handovers and in emails.
- The guidance outlined the conditions requiring senior medical review by a consultant. However, given that consultants were not present 24 hours a day, we were concerned that the process could not be implemented strictly in accordance with the guidance.
- Other risks were managed in the department. For example, to limit the risk of unauthorised use of medicines, alarms sounded if the cabinet was left open for longer than two minutes. If staff did not access the cabinet for two weeks, fingerprint details were automatically deleted and access denied. The risk of human error was reduced by using lights to clearly identify the drug to be selected, lowering the risk of picking the wrong box out of the cabinet. Nurses told us the system was easy to use and helped ensure medicines were stored and removed safely.
- Safety cones were placed in areas where floors were wet, for example following cleaning. This helped reduce the risk of slipping.
- Security staff were available 24 hours a day should support be required for staff or patients in the departments.
- Two isolation rooms were available for staff to care for patients with contagious illness, such as viral haemorrhagic fevers, or those who were more vulnerable to infection. This limited the risks to these or other patients being cared for in the department at the same time.

- The department had a range of vests which staff wore to identify their role when caring for patients. This helped make sure that staff knew which staff were responsible for specific care, such as orthopaedics, anaesthetics and radiology and reduced the risk of confusion which could affect care.
- Risk assessments were available to help staff identify potential risks to patients, such as falls, infection or safeguarding issues. This helped make them aware of those patients more likely to fall or sustain a pressure ulcer and take appropriate steps to limit the risk. However, these were not always used.

Nursing staffing

- During the previous inspection we were told the trust had recently recruited nurses following a review which showed staffing numbers needed to be increased.
- During this inspection we saw that staffing was arranged six weeks in advance using an electronic rostering system, which enabled staff to monitor levels accurately. The system alerted staff when staffing numbers on planned shifts dropped. The system also monitored annual leave, which was limited to 16% of total staff to help stop staffing falling to unsafe levels.
- The system worked to schedule ten nurses during the day and eight overnight. One additional nurse worked a twilight (late evening to early morning) shift. In total, 81 nurses were employed in the emergency care centre.
- When staffing levels were low, staff acted to minimise the impact and keep patients safe. For example, on the evening of our inspection, nurse coordinators reduced triage capacity to free staff to care for patients in bays. Additionally, staff told us that they prioritised maximum staffing at night when there was less managerial support in the hospital.
- The 'minors' area was predominantly staffed with nurse practitioners, which freed medical staff to provide care for the more unwell patients.
- A handover took place each morning and evening, which enabled staff to exchange details about each patient in the department. We observed one handover where two nurse coordinators discussed patients in each bay giving details of their presenting complaint, progress and care plan before discussing general information, such as deep cleaning schedules, staffing and hospital bed capacity.
- Debriefs for staff were held at the end of shift. This provided an opportunity for staff to discuss challenges or successes and to receive or provide support to colleagues. We observed a debrief take place where staff discussed how their patients had been cared for, how busy the department had been and what their plans were for scheduled days off.

Medical staffing

- In our previous inspection we saw that there was sufficient medical cover in the departments.
- During this inspection staff confirmed that five consultants, three middle grade doctors, three clinical fellows (doctors undertaking specialist academic research) and ten junior doctors worked in the ECC. Medical staff working in the PECC rotated from Rainbow Ward or the main ECC.
- Consultants were based in the departments between 8am and 11pm Monday to Friday and 8am until 9pm at weekends, with availability on an on call basis outside these hours.
- At the time of inspection there was one vacancy for a middle grade doctor, which was being covered by locum doctors.
- We reviewed the medical staff rota, which showed staffing levels were generally maintained, with no regular gaps in either middle grade or junior doctor shifts.

Major incident awareness and training

- During our previous inspection we found that the trust had a policy to deal with major incidents and undertook scenarios with staff to ensure readiness should an incident be declared.
- During this inspection we spoke to staff who described major and chemical incident plans, plus associated actions should an incident occur.
- A staff notice board dedicated to managing major incidents displayed flow charts and action cards, with step by step actions for scenarios, such as chemical incidents or patients arriving with suspected blood borne viruses who required isolation. We reviewed the care pathway designed to help staff care for patients with a blood borne virus, such as Ebola. However, the document had a review date of 2015, which left us concerned it had not been reviewed or updated recently.
- We reviewed a room assigned for patients requiring decontamination following a chemical incident, which was also used to take blood samples on an occasional

basis. The room stored large equipment, such as tents for patients to shower in and had floor to ceiling tiling and an open shower area. Whilst we were assured the room was clean and did not pose a risk to patients, we remained concerned that it was not an ideal environment to use for patient care.

- A business continuity plan helped staff make sure services continued when incidents with the potential to cause disruption occurred. The plan provided staff with guidance for managing day to day business when events occurred, such as severe weather, fuel or supply shortages or industrial action. Other plans were also in place to manage chemical incidents and pandemics.

Services for children and young people

Safe	Requires improvement
Overall	Requires improvement

Information about the service

Wrightington, Wigan and Leigh NHS Foundation Trust provide a range of paediatric services at the Royal Albert Edward Infirmary (RAEI). These include neonatal critical care, high dependency care and special care for new born babies in the neonatal unit and high dependency care, medical care and paediatric surgery for children aged 0-16 years on Rainbow ward. Emergency care is provided in the Paediatric Emergency Care Centre (PECC) within the Accident and Emergency (A&E) department and outpatient services for children with ongoing medical needs are provided at the Thomas Linacre Centre. Rainbow ward is situated on the fourth floor of the RAEI.

We performed a focused inspection of Rainbow ward at RAEI on the evening of 17 March 2017 in response to concerns regarding the care of children and young people. We observed a nursing handover and a medical handover, spoke with five staff, reviewed four prescription records and six sets of patient records.

Summary of findings

We rated children and young people's services as requires improvement for safe because:

- There was one never event reported by the trust on Rainbow ward between and 1 March 2016 and 31 March 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The investigation report following the never event noted discussion with the child's parent, however, evidence of duty of candour was not fully documented.
- Cleaning checklists were observed, however, these were not consistently completed in all areas.
- Medicine fridges were secured and fridge temperatures were monitored and audited, however, the resetting of the fridge thermometer was not consistently recorded in line with trust policy.
- The refrigerator in the milk room was not in use at the time of our inspection and a review of incidents recorded between 1 March 2016 and 31 March 2017 did not highlight this issue.
- Compliance rates for mandatory and safeguarding training were below the trust target of 95%. Compliance rates for safeguarding children level three was 77.8% for paediatric medical staff and 28.6% for registered paediatric nurses on Rainbow ward at April 2017.
- Records we reviewed showed that four out of five records did not have appropriate actions taken on triggering Paediatric Early Warning Score (PEWS).

However,

Services for children and young people

- Staff knew how to report incidents, lessons learnt were shared with staff and staff described changes in practice as a result of incidents.
- Paediatric mortality and morbidity meetings were held to review deaths and adverse incidents to enable lessons to be learnt and highlight areas for improvement.
- The ward was visibly clean and staff adhered to current infection prevention and control guidelines. Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and an infection control spot audit completed in March 2017 indicated staff on Rainbow ward achieved a compliance rate of 96%.
- Emergency resuscitation equipment was in place and records in areas we reviewed indicated this was consistently checked.
- Safety testing for equipment was in use and a bedrails assessment was completed on admission.
- All medicines on Rainbow ward were found to be in date and stored securely in a locked cupboard, as appropriate, and in line with legislation.
- Safeguarding policies and procedures were in place across the trust. Staff we spoke with were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Between January 2017 and March 2017, there was a member of staff trained in Advanced Paediatric Life Support (APLS) on almost every shift.
- Staff competencies for delivering care in the high dependency unit were in place and included both equipment and scenario based training and 28 out of 31 eligible staff had received tracheostomy training.
- The nursing staff ratio on Rainbow ward was a maximum of 1:5 for both general paediatric patients and paediatric surgical patients. Between 1 January and 31 March 2017 this had been achieved on all but four shifts (98.5%).

Are services for children and young people safe?

Requires improvement

Incidents

- Incidents were reported using an electronic reporting system. Staff could describe the type of incidents they would report and demonstrated the process.
- Lessons learnt were shared with staff at ward meetings, via the 'comms cell' noticeboard and by email. Staff discussed changes in practice following incidents.
- There was one 'never event' reported by the trust on Rainbow ward between and 1 March 2016 and 31 March 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. The never event involved a child becoming trapped in a bedrail. An investigation was completed and a review of the bedrails Standard Operating Procedure (SOP) and bedrail risk assessment was undertaken in response.
- We reviewed the investigation report relating to the never event, which noted discussion with the child's parent, however, evidence of duty of candour was not documented.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Between 1st March 2016 and 31 March 2017, 162 patient safety incidents were recorded on Rainbow ward. Of these, 155 were reported as low / 'minor injury or no harm'.
- Of the incidents classified as 'low/minor injury or no harm' 23 related to medication and five related to staffing.
- Paediatric mortality and morbidity meetings were held and attended by medical staff, child health governance

lead and the Advanced Paediatric Nurse Practitioner (APNP). These are meetings to review deaths and adverse incidents to enable lessons to be learnt and highlight areas for improvement.

Cleanliness, infection control and hygiene

- The ward was visibly clean. Staff adhered to current infection prevention and control guidelines, such as the 'arms bare below the elbow' policy. Personal protective equipment, such as aprons and gloves were readily available. Staff described the process if an area of the ward required immediate cleaning out of hours.
- Hand washing facilities, including hand gel, were readily available in prominent positions in each clinical area.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Cleaning checklists were observed, however, these were not consistently completed in all areas.
- Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and we saw evidence of these being used in the high dependency area.
- An infection control spot audit completed in March 2017 indicated staff on Rainbow ward achieved a compliance rate of 96%.

Environment and equipment

- Rainbow ward was brightly decorated and had a large, central playroom.
- Access to the ward and treatment areas was controlled and staff could observe visitors on a television monitor before they entered the ward.
- Emergency resuscitation equipment was in place and records in areas we reviewed indicated this was consistently checked.
- Safety testing for equipment was in use on Rainbow ward and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Bedrails were observed on nine beds on Rainbow ward. All were of the type recommended following a previous incident and 20 new beds had been ordered for the ward. Staff told us a review of cots on the ward was also in progress.
- A bedrails assessment was completed on admission, which included a review of the patient's mental state and mobility, as well as observation of the rails to ensure correct fitting and the suitability of the mattress.

Medicines

- All medicines on Rainbow ward were found to be in date and stored securely in a locked cupboard, as appropriate, and in line with legislation. Medicine cupboard keys were held by the qualified nurses on the ward.
- Controlled drugs were stored securely and accurate records maintained in accordance with trust policy, however, the expiry date had rubbed off one set of medicines. Staff told us this was due to handling when completing twice daily checks.
- Between 1st March 2016 and 31 March 2017, 23 incidents were recorded involving medicines on Rainbow ward.
- Temperature readings of refrigerators that store medicines and vaccines should be between two degrees and eight degrees centigrade. Medicine fridges were secured and fridge temperatures were monitored and audited, however, the resetting of the fridge thermometer was not consistently recorded in line with trust policy and action taken when the fridge deviated from the acceptable range was not evident.
- The refrigerator in the milk room was not in use at the time of our inspection. Staff told us the refrigerator and room readings had been reading higher than the acceptable range and this had been reported as an incident and was on the risk register. However, a review of incidents recorded between 1 March 2016 and 31 March 2017 did not highlight this issue and it was not entered on the Rainbow ward risk register provided by the trust.
- We reviewed four prescription charts during our inspection. Of those reviewed all were legible, signed and dated and had the age and weight of the child and any allergies recorded.
- Pharmacy support was available on Rainbow ward and a process was in place to obtain medication out of hours.
- Medicine safety updates were available for staff and these were observed in the five point communication folder on the ward.

Records

- Patient records on Rainbow ward consisted of paper records at the bedside, such as observation charts while demographic information, medical and nursing records and prescription charts were electronic.

- We reviewed six sets of records on Rainbow ward. All were signed and dated and had the name and grade of the reviewing doctor or nurse and a diagnosis and management plan clearly documented. However, only two out of five records indicated the patient had been seen by a consultant within 14 hours as recommended in the Facing the Future Standards 2015 and only two out of five had observations recorded, Paediatric Early Warning Score (PEWS) calculated and subsequent actions documented.
- Results from the annual clinical case note audit completed in May 2016 indicated that the 75% standard was met for recording birth and family history, social history and past medical history. However, records showed the timing of entries, designation of author, bleep number and patient identification number on each record sheet fell below the standard.
- Recommendations from the 2016 audit report for Child Health included ensuring the Patient ID number was entered on every history sheet, the timing of every entry was undertaken, ensuring errors were crossed, dated and signed and annual audits continued.
- Despite electronic records being introduced into the trust in June 2016, the Clinical Record Keeping Policy had not been updated to include electronic records at the time of our inspection; however, an updated policy was subsequently approved in May 2017.
- A small pilot audit of the Health Information System was completed in October 2016 to assess compliance and future audit requirements in relation to electronic record keeping; however, Rainbow ward was not included in this pilot.

Safeguarding

- Safeguarding policies and procedures were in place across the trust and these were available electronically for staff to refer to. Staff we spoke with were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Staff knew how to contact the safeguarding team for support and advice and trust wide group safeguarding supervision was available for all staff who had responsibilities for assessing the needs of babies, children and young people.
- Safeguarding training formed part of the trust's mandatory training programme and included child sexual exploitation (CSE), child trafficking and female genital mutilation (FGM) at level two and level three and, additionally, honour based violence (HBV) at level three.
- The safeguarding children and young people: 'roles and competencies for health care staff' Intercollegiate Document (2014) states that clinical staff who contribute to assessing, planning, and evaluating the needs of a child or young person should be trained to safeguarding at level three.
- The trust safeguarding training target was 95%. Compliance rates for paediatric medical staff for safeguarding children level three was 77.8% at April 2017. The compliance rate for registered paediatric nurses on Rainbow ward for safeguarding children level three was 28.6% at April 2017. The combined compliance rate for all staff on Rainbow ward excluding medical staff was 15.7% at April 2017.
- At our last inspection we found 81% of staff on Rainbow ward had completed level three safeguarding children training. The trust had a plan in place to significantly improve compliance by July 2017.
- A lead doctor and lead nurse for safeguarding children were identified within the trust. A safeguarding escalation pathway was displayed at the nurses' station, with contact details for the named nurse, head of safeguarding, named doctor and senior safeguarding nurses.
- Staff we spoke with advised they had attended safe sleep training. Safe sleeping advice informs parents of actions they can take to reduce the chance of Sudden Infant Death Syndrome (SIDS).
- Staff advised that part of the ward admission process was to enquire if children had an allocated social worker and procedures were in place to identify if children were subject to a child protection plan. We observed a completed safeguarding pro forma in a set of patient records that showed communication with children's social care.
- Safeguarding bulletins and seven minute briefings were available in the five point communication file to inform staff and we observed briefings relating to honour based violence, forced marriage and trafficking.

Mandatory training

- Staff received training in areas, such as fire safety, infection control, information governance and resuscitation. Training was delivered online as well as face to face and staff told us they received a reminder when mandatory training was due.
- The trust target for mandatory training was 95%. Compliance rates for paediatric medical staff ranged from 100% for topics, such as fire safety, health and safety and infection control, to 88.9% for conflict resolution and resuscitation. Compliance rates for registered paediatric nurses on Rainbow ward ranged from 96.4% for fire safety, health and safety and infection control, to 67.9% for resuscitation.

Assessing and responding to patient risk

- The trust used Paediatric Early Warning Scores (PEWS) to monitor the condition of a child on Rainbow ward. This included observation of the patient's vital signs, such as pulse and respiratory rate. If a child's condition deteriorated, the score for the observations increased and gave an indication that intervention may be required.
- Records we reviewed showed that four out of five records did not have appropriate actions taken on triggering PEWS. The scoring system indicated that observations should be repeated within half an hour if they fall into the green area. In all four cases, however, this was not documented and one set of records showed observations were not repeated for nine and a half hours.
- The PEWS scoring system also indicates a need for discussion with medical staff if observations are recorded in the green area on three consecutive occasions. In one set of records, we observed observations recorded in the green area on the PEWS chart consistently on 13 occasions, without any evidence of discussion with medical staff.
- Results of PEWS audits on Rainbow ward were requested from the trust, however, this information was not provided.
- The Royal College of Nursing document 'Defining staffing levels for children and young people's services' identifies as a core standard to be applied in services providing health care for children and young people, for at least one nurse per shift in each clinical area (ward/department) to be trained in Advanced Paediatric Life Support/European Paediatric Life Support (APLS/EPLS), depending on the service need.
- At our last inspection we found only the Advanced Paediatric Nurse Practitioner (APNP) had completed APLS training. At this visit staff told us that 11 out of 34 nurses and the APNP were APLS trained and there was an APLS trained nurse on almost every shift. Data from the trust indicated that in January 2017, 90 shifts out of a total of 93 had at least one APLS trained member of staff, indicating a compliance rate of 96.7%. In February 2017, at least one APLS trained member of staff was on duty on 83 shifts out of a total of 84, indicating a compliance rate of 98.8% and in March 2017, at least one APLS trained nurse was on duty every shift.
- Guidelines were in place for the management of paediatric sepsis, however, the paper copy we observed in the High Dependency Unit had a review date of 20 June 2016.
- At our last inspection, no members of staff were competent to care for patients with tracheostomies. During the responsive inspection, staff told us tracheostomy training had been delivered to qualified members of staff and data from the trust showed that 28 out of 31 eligible staff were compliant.
- Staff competencies for delivering care in the high dependency unit were in place and included both equipment and scenario based training.
- Children and young people who required child and adolescent mental health services (CAMHS) were admitted to the ward from the accident and emergency department and staff told us they were seen by the CAMHS team the next working day. However, we observed a set of records of a patient admitted on 15 March 2017, who had no documented consultation with the CAMHS team at the time of our inspection.
- Staff could access advice from the CAMHS urgent response team if required.

Nursing staffing

- The expected and actual staffing levels were displayed at the entrance to Rainbow ward.
- No formal acuity tool was in use; information from the trust indicated patient acuity was assessed by senior nurses and clinicians at each shift. An escalation process was in place in the event of low staff numbers. Staff reported this was helpful and we observed an escalation flowchart displayed on the ward.
- Between 1st March 2016 and 31 March 2017, five incidents were recorded involving staffing on Rainbow ward.

Services for children and young people

- At the time of our inspection, the staff ratio on Rainbow ward was a maximum of 1:5 for both general paediatric patients and paediatric surgical patients. We reviewed staffing and occupancy data for January 2017, February 2017 and March 2017, which indicated this number had been exceeded on only one shift in January, two shifts in February and one shift in March. On all four occasions an escalation bed had been used for either part or the duration of the shift.
- The trust was progressing towards the shift leader on Rainbow ward becoming supernumerary and this had been achieved on 84 shifts out of a total of 93 (90.3%) in January 2017, 71 shifts out of a total of 84 (84.5%) in February 2017 and 77 shifts out of a total of 93 in March 2017 (82.8%).
- Rainbow ward had a two bedded bay designated as a High Dependency Unit (HDU). At our last inspection, staffing rotas did not identify an appropriately trained member of staff for the HDU should any patients be admitted. Staff told us a nurse was now identified to cover HDU when the off duty was completed and data from the trust indicated the paediatric HDU staff ratio of a maximum of 1:2 had not been exceeded on any shift between 1 January 2017 and 31 March 2017.
- Monthly Safe Staffing reports were produced, which detailed average fill rates, sickness and vacancies across the trust, as well as falls, drug errors and patient experience. Reports compiled between December 2016 and February 2017 showed Rainbow ward average fill rates for registered nurses ranged from 95.7% to 103.96% on day shifts and 92.1% to 100.1% on night shifts. Average fill rates for clinical support workers in the same time frame ranged from 83% to 88.8% on day shifts and 41.9% to 53.3% on night shifts.
- Sickness rates on Rainbow ward between December 2016 and February 2017 ranged from 6.3% to 14.1% and there were no vacancies recorded.
- We observed a taped nursing handover, which provided name, age, diagnosis, observations, medications and treatment plan of patients on the ward. It also detailed if parents or carers were resident on the ward.

Medical staffing

- The trust employed eleven paediatric consultants, four of which were based in the community. The seven acute paediatric consultants provided cover 24 hours per day and took part in a "Consultant of the week" rota.
- At the time of the inspection there was one vacancy for a middle grade doctor, which was being covered by locum doctors.
- We reviewed medical rotas for the period 6 February 2017 to 2 April 2017; minimum staffing levels were met, with no regular gaps in either middle grade or junior doctor shifts.
- Medical staff we spoke with told us they had no staffing concerns at junior level and only one shift had not been covered at Specialist Registrar grade (SPR) since February 2017, however, at the time this had been covered by the consultant.
- Junior doctors told us they had dedicated teaching sessions and they felt supported.
- We observed a clinical handover, which included both written and verbal information regarding patients on Rainbow ward. Details of name, age, diagnosis and management plans were provided, as well as results of investigations and liaison with other professionals.

Major incident awareness and training

- The trust had a major incident policy. Staff were aware of this and could locate it on the intranet.
- We observed a winter pressures escalation plan and standard operating procedure.
- Emergency planning formed part of the mandatory training requirement and compliance rates ranged from 96.4% for registered paediatric nurses on Rainbow ward, to 100% for paediatric medical staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure staff complete mandatory safeguarding children training appropriate to their role.
- The trust must ensure staff complete other mandatory training to maintain compliance in line with the trust target.
- The trust must ensure that tools to manage risk are used and recorded such as completing risk assessments and observations and taking appropriate action when triggering Paediatric Early Warning Scores (PEWS).
- The trust must ensure that patient records are accurate and complete.

Action the hospital SHOULD take to improve

In relation to children and young people services:

- The trust should ensure duty of candour is documented following a notifiable safety incident.
- The trust should ensure cleaning schedules are consistently completed in all areas.
- The trust should ensure the expiry date is legible on all controlled drugs.
- The trust should ensure the medicine fridge thermometer is reset in line with trust policy and action taken is documented when the fridge temperature deviates from the acceptable range.
- The trust should ensure the refrigerator in the milk room is available and fit for use.
- The trust should ensure current guidelines for the management of paediatric sepsis are available for staff.

In relation to urgent and emergency services:

- Ensure trust guidance is consistent throughout all departments in relation to the use of early warning scores, clinical observations and general monitoring of patients, and that where required, categories and frequency of monitoring is stipulated to ensure clarity.
- The trust should ensure that all staff use the same guidance relating to the frequency of observations and that
- The trust should ensure that sanitising gel is available in all dispensers
- Only store equipment in appropriate packaging and remove equipment that is not stored in this way.
- The trust should review the suitability of the room used to store major incident equipment in relation to taking blood samples from patients
- The trust should review the entrance and exit door to the paediatric emergency care centre with a view to reducing the risk of children or young people exiting the department.
- The trust should consider amending the checklists used on resuscitation trolleys to ensure any action to replace missing items can be documented to avoid potential confusion.
- The trust should consider introducing checklists to record that defibrillators have been checked rather than relying on printed strips stored in no particular order.
- The trust should obtain assurance and ensure that staff involved in assessing patients are aware of, or appropriately prompted to consider female genital mutilation
- The trust should ensure that guidance about conditions requiring senior medical review covers occasions when consultants are not on site and available only on an on call basis.
- The trust should ensure that the care pathway for caring for patients with a blood borne virus is up to date and that the latest version is displayed on the relevant noticeboard in the emergency care centre.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation :13 Safeguarding service users from abuse and improper treatment** **How the regulation was not being met:** **Systems and processes were not established and operated effectively to prevent abuse of service users. Training was not updated at appropriate intervals to keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns.** **This is because:** **The compliance rate for registered paediatric nurses on Rainbow ward for safeguarding children level three training was 28.6% at April 2017. The combined compliance rate for all staff on Rainbow ward was 15.7% at April 2017.** **The compliance rate in urgent and emergency services for registered paediatric nurses for safeguarding level three training was 58% and for adult nurses was 37%. The compliance rate for medical staff in the service was 24% at April 2017** **HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 13 (2)**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation :18 Staffing**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Termination of pregnancies Treatment of disease, disorder or injury	How the regulation was not being met: Training records showed that not all staff had received appropriate training as necessary to enable them to carry out the duties they are employed to perform This is because: Training figures for resuscitation for emergency care centre nurses was 80% and for medical staff was 52%. Overall, nurses in the ECC were 94% compliant and medical staff 63% compliant which was not in line with the trust target. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18 (2) (a)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation: 12 Safe care and treatment. How the regulation was not being met: Care and treatment was not provided in a safe way for service users. Assessments, planning and delivery of care and treatment did not respond appropriately and in good time to people's changing needs. This is because: Records we reviewed on Rainbow Ward showed that four out of five records did not have appropriate actions taken on triggering Paediatric Early Warning Scores (PEWS). HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) (2) (a)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

Surgical procedures

Termination of pregnancies

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation: 17 Good Governance.

How the regulation was not being met:

Records we reviewed were not always complete, or accurate in respect of each service user, including a record of the care and treatment provided and of decisions taken in relation to care and treatment provided.

This is because:

Patient records in urgent and emergency services did not always include necessary details such as staff name, signature or designation, patient risk assessment, recorded observations, early warning score or plan of action for care or treatment.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2) (c)