We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

University Hospitals Bristol Main Site

Bristol Royal Infirmary, Upper Maudlin Street,
Bristol, BS2 8HW

Date of Inspection: 19 November 2012  Date of Publication: December 2012

We inspected the following standards as part of a routine inspection. This is what we found:

**Staffing**  ✔ Met this standard
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>University Hospitals Bristol NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>The provider is an acute NHS foundation trust providing services across the Bristol and greater Avon area. The trust also provides specialist care to people from across the South West region. University Hospitals Bristol Main site provides acute services and includes, Bristol Royal Infirmary, Bristol Royal Hospital for children, Bristol Haematology and Oncology Centre, Bristol Heart Institute, St Michael's Hospital, Bristol Eye Hospital Bristol Dental Centre.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Acute services with overnight beds</td>
</tr>
</tbody>
</table>
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Family planning  
Management of supply of blood and blood derived products  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Transport services, triage and medical advice provided remotely  
Treatment of disease, disorder or injury |
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We reviewed all the information we have gathered about University Hospitals Bristol Main Site, looked at the personal care or treatment records of people who use the service, carried out a visit on 19 November 2012 and observed how people were being cared for. We talked with people who use the service, talked with carers and / or family members, talked with staff and talked with stakeholders.

We were accompanied on this inspection by two specialist advisors engaged by the commission.

What people told us and what we found

We issued a warning notice to the trust following our inspection on 5 September 2012. We had found that children on Ward 32 were at risk because there were not enough suitable staff to meet their needs. The notice required the trust to take action by 18 October 2012 to ensure that there were sufficient numbers of suitably qualified and experienced staff at all times. The trust submitted a plan to us setting out the actions they would be taking by this date.

We returned to the hospital on 19 November 2012. The inspection team included a consultant surgeon and a nurse, who were both experienced in paediatric cardiology.

We found that Ward 32 was now designated as a specialist cardiac ward. We were told that the number of beds on Ward 32 had reduced and two high dependency beds created on the Paediatric Intensive Care Unit (PICU). Other developments included a new system for assessing if children could stay on Ward 32 or needed care in a high dependency bed.

Parents on Ward 32 told us that staff were available to them when needed. One parent said "the ward seems quieter than it was in the summer and more controlled". Staff made comments such as "it feels less anxious" when talking about the changes they had seen on Ward 32.

Overall the risk to children on Ward 32 had reduced because staff were caring for fewer children with a lower level of dependency. We found that the trust had complied with the warning notice.

You can see our judgements on the front page of this report.
More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
### Staffing

<table>
<thead>
<tr>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>There should be enough members of staff to keep people safe and meet their health and welfare needs</strong></td>
</tr>
</tbody>
</table>

### Our judgement

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

### Reasons for our judgement

This inspection only concerned the Bristol Royal Hospital for Children, which is one part of the trust’s location known as 'University Hospitals Bristol Main Site'. As at our previous visit to the hospital on 5 September 2012, we spent time on Ward 32 and on the Paediatric Intensive Care Unit (PICU).

Following our inspection on 5 September 2012 we asked the trust to tell us what immediate steps they had taken in response to the warning notice.

The trust wrote to inform us that Ward 32 only admitted children who were cardiac patients. The ward sister, who was on maternity leave, had been temporarily replaced by a senior nurse with leadership experience in paediatric cardiac services and paediatric intensive care. This was now a full time supervisory role.

The trust told us the senior nurse responsible for PICU and Ward 32 visited Ward 32 daily to support staff and facilitate clinical skills training. Dependency levels of children and the skill mix and experience of staff were also being closely monitored. Information we received confirmed that the trust had taken action to address the gaps in specialist training for staff on Ward 32.

On 19 October 2012 we received information from the trust about the further action they had taken. We were told that PICU bed numbers had been reduced by one and two cardiac high dependency beds had been created. The bed numbers on Ward 32 had been reduced from 16 to 12. As a result of these changes the registered nurse to child ratio had increased to one to three during the day and one to four at night.

The trust had restricted the cardiac surgical programme in line with the capacity reduction on Ward 32 and PICU. The cardiac surgery waiting list remains under regular scrutiny and they monitor the need to call upon other specialist centres.
An action plan was sent to us on 5 November 2012 outlining the steps taken to comply with the compliance actions and warning notice issued. We were informed about plans in progress to establish a dedicated High Dependency Unit on Ward 32.

When we visited PICU at 10 am on 19 November 2012 staff told us there were 18 beds, 15 of which were occupied. There was a mix of high dependency beds (one registered nurse to two children) and intensive care beds (one registered nurse to one child). Staff told us they were using a new system for assessing whether children needed to be cared for in an intensive care or high dependency care bed on PICU or if their assessed needs could be met in a specialist bed on Ward 32.

We asked to see the staff rota and communication book on PICU. Records from 18 October 2012 showed that there had been gaps in the rota due to staff sickness. However, we saw that those gaps had been filled by experienced PICU staff.

We met with a member of the outreach team who confirmed they followed up children transferred from PICU to Ward 32 for 48 hours. They told us they were not included in the staffing numbers on Ward 32. They explained their role was advice only, but on occasions in the past they had been asked to cover a shift on Ward 32. This arrangement to cover a shift had not been requested since 18 October 2012.

When we arrived on Ward 32 at 10am staff told us there were 12 beds open instead of 16. We were informed there were nine children on the ward who had been admitted due to their cardiac condition. Staff confirmed that Ward 32 now only admitted children with cardiac needs.

At the time of our visit there were four registered nurses and one health care assistant on duty on Ward 32. There were also two student nurses and a cardiac nurse specialist was available to provide advice to parents and staff. The acting ward manager confirmed their role was now supervisory. Staff told us that the staffing ratio at night was three registered nurses and one health care assistant to 12 children.

The parents who we met with on Ward 32 said that the nurses were available to them when needed. They commented positively about their dealings with staff, who were described as friendly and "very helpful". One parent said "they ask us the right questions".

Staff we spoke with told us that changes on Ward 32 had made a difference to their work. One nurse for example told us that they could spend more time with the children and another commented that the day to day work was "easier to manage".

During our visit to Ward 32 we asked to see the staff rota and communication book. We saw there had been gaps in the rota after 18 October 2012 due to staff sickness, but records confirmed that there were effective measures in place to ensure there were adequate staffing levels in place.

Staff on Ward 32 told us that the ward was using the new system for assessing whether a child's needs could be met on the ward, or whether they needed care in a high dependency or intensive care bed. We did not see records of children's daily dependency levels or of staffing levels in relation to the number of children on the ward and their ages. This information would have shown how the system was being implemented on a day to day basis. However, staff were aware of the criteria being used for determining whether a child's need could be met on the ward and said that these were being kept to. They told us
of occasions when a child had needed to move from the ward to a high dependency bed on PICU because their needs had changed.

Following our visit on 19 November 2012 we requested further information from the trust about the changes that had been made on PICU and Ward 32. This information included: staff rotas for both medical and nursing staff, staff training needs analysis for Ward 32, minutes of governance meetings and information about the trust's risk register.

From the information we received from the trust and our findings from the visit on 19 November 2012 we found there were enough qualified, skilled and experienced staff on PICU and Ward 32 to meet children's needs.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th>Met this standard</th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action needed</td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td>Enforcement action taken</td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
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</tbody>
</table>
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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<thead>
<tr>
<th>Outcome</th>
<th>Regulation</th>
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<td>Respecting and involving people who use services</td>
<td>17</td>
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<td>Consent to care and treatment</td>
<td>18</td>
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<td>Care and welfare of people who use services</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>24</td>
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<td>Safeguarding people who use services from abuse</td>
<td>11</td>
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<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
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<td>Management of medicines</td>
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<tr>
<td>Safety and suitability of premises</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>21</td>
</tr>
<tr>
<td>Staffing</td>
<td>22</td>
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<tr>
<td>Supporting Staff</td>
<td>23</td>
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<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>10</td>
</tr>
<tr>
<td>Complaints</td>
<td>19</td>
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<td>Records</td>
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</tbody>
</table>

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.