Review of compliance

University Hospitals Bristol NHS Foundation Trust
University Hospitals Bristol Main Site

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<tr>
<th>Region:</th>
<th>South West</th>
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<tr>
<td>Location address:</td>
<td>Bristol Royal Infirmary</td>
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<td>Upper Maudlin Street</td>
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<td>Bristol</td>
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<td>BS2 8HW</td>
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<tr>
<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<tr>
<td>Date of Publication:</td>
<td>October 2012</td>
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<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, the Bristol Royal Infirmary, Bristol Royal Hospital for Children, Bristol Haematology and Oncology Centre, Bristol Heart Institute, St</td>
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Michael's Hospital, Bristol Eye Hospital and Bristol Dental Hospital.
Our current overall judgement

University Hospitals Bristol Main Site was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 13 - Staffing
Outcome 14 - Supporting workers

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 5 September 2012, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We carried out this responsive inspection as a result of concerns raised with the Care Quality Commission about the care and staffing levels on Ward 32. The inspection did not look at the clinical outcomes for children whose stay in hospital included time spent on Ward 32.

Children were cared for on Ward 32 with a spectrum of treatment ranging from medical management, day case/short stay interventions, and pre/postoperative cardiac surgery. Children were treated from the southwest region and South/West Wales regions as part of an established cardiac network.

We contacted commissioners prior to our visit to Ward 32. They raised no concerns with us about the service being provided on Ward 32.

During our visit we focused on Ward 32, but we also spent time on the Paediatric Intensive Care Unit (PICU) so we could understand the working relationship between these two services. Both services were located in Bristol Royal Hospital for Children which is part of...
the University Hospitals Bristol main site.

During our visit to Ward 32 we spoke with six parents, five registered nurses, two health care assistants and two doctors. The majority of parents we spoke with on Ward 32 told us they had the information they required about their child's care and treatment. One parent said "This is an amazing place. Lovely staff, lovely doctors. It is reassuring for our child. They really try to be supportive. They treat the whole family. You can ring the ward from home especially in the run up to the operation. Communication is good. There is always somebody you can ask".

Another parent told us "care is excellent on Ward 32, but the first time we visited Ward 32 which was about a month ago, we were told the wrong information about the operation day. Our child had a cold so they could not operate. We saw five different doctors at the time who gave us different information. The second time our child was admitted we found the communication was much better. The surgeon explained everything he was going to do step by step. We were reassured".

Staff we spoke with were committed to ensuring that children and their parents were involved in the decision making process about their care and were constantly aware that they needed to ensure dignity and privacy was maintained at all times.

All parents we spoke with on Ward 32 told us that their child had received good treatment and care and they had received good support.

One parent said that their child had never had to wait for feeds. They told us "if my child's named nurse was busy, then another nurse would take over. It is good team work. They all muck in together. Even after a 12 hour shift, one nurse still came to see me. They wanted to show me how to wind my baby another way. They had agreed to do that earlier in the shift but did not have time".

Another parent told us "three to four weeks ago there was a bank nurse on duty for two nights as they were short of staff". They said that "this bank nurse was fine, but there was no continuity or communication. They did not understand our routine and woke us up when myself and child were settled for the night".

On the day of our visit to Ward 32, parents we spoke with did not report a staff shortage. They did however comment that the staff on Ward 32 were very busy. They also commented on staff shortages on other days they had been present on the ward.

When we visited Ward 32 we found that the trust was not reducing the risk of children receiving unsafe or inappropriate care, treatment and support. This was due to the fact that 'high dependency care' was being delivered on Ward 32 without adequate staffing levels over a sustained period of time. The trust had established registered nurse staffing levels, but these did not reflect the high dependency of some children cared for on the ward.

Medical and nursing staff told us about the impact that the current staffing levels were having on the care and service being provided. They told us that at times observational checks do not get done or are reduced and "because of the overstretched nature of Ward 32 there was not enough time for staff to communicate with families". 
Staff told us how they tried to alleviate staffing difficulties, for example by working flexibly and taking fewer breaks. Also that the children's needs fluctuated so allocations were arranged so that the less experienced staff cared for those children who had a lower level of dependency.

What we found about the standards we reviewed and how well University Hospitals Bristol Main Site was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

The provider was meeting this standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People who used the service were generally safe, but there were inherent risks to their outcome, health and wellbeing which the trust had been aware for a considerable period of time, but had not effectively addressed.

The provider was not meeting this standard for the regulated activity: treatment of disease, disorder and injury. We judged that this had a moderate impact on people using the service.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

There was not sufficient qualified, skilled and experienced staff to meet people's needs.

The provider was not meeting this standard for the regulated activity: treatment of disease, disorder and injury. We judged that this had a major impact on people using the service.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider was not meeting this standard for the regulated activity: treatment of disease, disorder and injury. We judged that this had a moderate impact on people using the service.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been
taken.

We have taken enforcement action against University Hospitals Bristol NHS Foundation Trust.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the Guidance about compliance: Essential standards of quality and safety
Outcome 01: 
Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

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<td>The provider is compliant with Outcome 01: Respecting and involving people who use services</td>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>Parents we spoke with during our inspection felt that they had been given excellent and supportive information. The majority of parents we spoke with on Ward 32 told us they had the information they required about their child's care and treatment. One parent told us about the 'Welcome Guide' they had received. A copy of this guide was in their child's room. They had also been shown around the ward while they were still in the maternity hospital. They told us that they thought that this was useful preparation for their child's stay on Ward 32.</td>
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<td>Another parent said &quot;This is an amazing place. Lovely staff, lovely doctors. It is reassuring for our child. They really try to be supportive. They treat the whole family. You can ring the ward from home especially in the run up to the operation. The staff come and see you in PICU. There is a continuity of staff here. They are very involved in care. We have been kept well informed. I would speak to named nurse or cardiac liaison nurse if I had a problem. Communication is good. There is always somebody you can ask&quot;.</td>
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<td>Parents told us &quot;care is excellent on Ward 32, but the first time we visited Ward 32 which was about a month ago, we were told the wrong information about the operation day. Our child had a cold so they could not operate. We saw five different doctors at...&quot;</td>
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the time who gave us different information. We had to go home until our child was better, but had spent time in the hospital waiting. The second time our child was admitted we found the communication was much better. The surgeon explained everything he was going to do step by step. We were reassured".

Another parent also told us about the number of times that their baby's operation had been postponed. They told us that they recognised that there may have been other priorities at the time which delayed the operation, but said "it did create a lot of difficulties for us on the day".

A doctor confirmed that frequent cancellations on the proposed day of admission took place as a result of pressure on beds and lack of dedicated staff to coordinate admissions. We were told that the impact of this was made worse as families set off from Cornwall and South Wales very early and so cannot be contacted until arrival when they were turned away as there was sometimes no bed.

We observed that some children and parents were waiting in the corridor of the Ward 32 prior to being admitted to the department. We were told by the staff that they had access to facilities within the department to ensure their privacy for, example, when changing their clothing and accessing the toilet facilities.

Parents told us "if you need to take break for a bit of privacy and time away from your child there is a family room for parents to use, but sometimes it is used when children and their parents are waiting to be admitted to the ward". They told us that a few parents had mentioned the same problem and they said "parents find it difficult if they just needed a bit of time to themselves".

The provider might find it useful to note that although there were systems in place to ensure the safety of children waiting to be admitted to Ward 32, the corridor, reception area and family room (if in use) did not ensure children's and their parents' privacy and dignity.

We observed children being supported in a professional manner. Parents were informed of their child's treatment. We saw that consent for surgical procedures was gained from parents.

During our visit we saw a registered nurse from PICU come to introduce herself to a child and parent on Ward 32 in preparation for the child's operation. We saw good clear communication between nurse and the parent and observed how the parent was put at ease by the answers they received.

All the people we spoke with on Ward 32 said they and their child had been treated with dignity and respect.

One parent said "the staff were attentive without being intrusive". They told us how the staff knocked on the door of the room before coming in. Parents told us about being on first name terms with staff and feeling welcome on the ward. We heard how new staff always introduced themselves and read their child's notes.

Other evidence
All cubicles within Ward 32 had curtains or screens around them. Notices reminding
staff about privacy and dignity were displayed and these could be attached to the
curtain to inform staff that treatment was taking place or privacy was needed. We
observed staff asking permission prior to entering a cubicle where the curtains were
drawn. Staff told us that all the health professionals involved with each child and their
parents were careful about confidentiality, and privacy and dignity.

We were shown the treatment room where children could be seen in private. Staff told
us this arrangement also helped to separate a child’s bed space from treatment.

We were informed about the NHS patient surveys carried out nationally and saw that
the trust monitored actions required as a result of this. In addition we saw that the trust
also carried out their own surveys and engagement with children and their parents.

We saw that the trust takes steps to engage with children and parents about their
experience in hospital. We saw evidence of the outcomes of satisfaction surveys in
Ward 32.

We were also provided with evidence of the trust's engagement with children and
parents who used the service and had raised complaints. Information was displayed
about the results of a patient’s survey which had taken place from April to June 2012.
There had been 43 respondents.

In addition we saw that the trust regularly reviewed concerns and complaints raised by
children and parents who used the services. The patient experience group within the
trust reviewed this information along with other matters to improve the patient
experience within the trust. We saw that actions were identified as a result of the
discussion and pertinent issues were raised for discussion by the Trust Management
Executive Group.

We saw that there were comment cards and boxes on Ward 32 for children and their
parents to make comments about their care. Other information available on Ward 32
for parents included a newsletter which was on the notice board in the reception area.

**Our judgement**
People’s privacy, dignity and independence were respected. People's views and
experiences were taken into account in the way the service was provided and delivered
in relation to their care.

The provider was meeting this standard.
Outcome 04:
Care and welfare of people who use services

What the outcome says
This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

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<th>Our judgement</th>
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<tr>
<td>The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.</td>
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<th>Our findings</th>
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| **What people who use the service experienced and told us**  
We spoke with six parents of children on Ward 32 who gave us mainly positive comments about the staff and their caring approach. We did not look at the clinical outcomes for children whose stay in hospital included time spent on Ward 32.  
   
One parent said "the staff keep in touch. They usually put their head around the door to check things are OK when walking past. It is not just the named qualified nurse or the health care assistant that do this. If the named nurse is not available another nurse will support us. Staff have worked well to control my child’s pain. Staff try to find out how pain is affecting my child. They know what to ask them in a way that they understand".  
   
All parents we spoke with on Ward 32 told us that their child had received good treatment and care and they had received good support. One parent said "It is a wonderful place. I am very impressed with staff. They give emotional support. They utilise time well and talk to parents". This parent also told us that their child "had breathing problems the other night". They said "the nurse came straight away to check them. They are all supportive; nurses, consultants and doctors. My child has not been in pain and there has been no delay in treatment. My child had a problem with a wound and they organised a specialist tissue viability nurse. If I had a trumpet I would blow it for them".  
   
Another parent said "the support from cardiac nurses and other staff such as the physiotherapist and dietician has been excellent. Our child loves the play therapy. The
team are great. Look at all the art and craft activities they have been doing. We have a
daily named nurse and we are kept up to date”.

A third parent told us "the care side is excellent. You do not feel you are bothering
them. Our child was sick the other night. The nurses came to help straight away. Our
child has not been in pain. They try to find out from our child if they are in pain and they
talk to us. We feel as parents we have been in control. Communication is excellent.
The staff explained the care plan to me. They will explain if there are any delays in
caring for our child”.

Whilst we were speaking with a parent we observed a registered nurse come into the
room to record observations they had made on the child. We observed that this was
carried out in an efficient and careful way. We also saw that the registered nurse spoke
in a caring way to the parents about what they were doing and more general things.

Other evidence
Prior to our visit to Ward 32 we asked for information from the trust about high
dependency care provision on the ward. We were told by the trust in their report ‘CQC
response: Staffing levels Ward 32’ (High dependency care section), sent on 20 August
2012, that currently all high dependency provision was managed in Bristol Royal
Hospital for Children by using support from the paediatric outreach team. The trust told
us that this team, which included a senior nurse with a paediatric acute and critical care
qualification, supported staff to care for children who were acutely unwell or triggered a
high dependency clinical score on the paediatric early warning assessment tool which
included all children discharged from PICU for a period of 48 hours. We were told that
the team was also part of the Cardiac Arrest / Emergency Call Team and will support
the Emergency Department when children are unstable in the Resuscitation
department.

We found that Ward 32 admitted children from PICU who were recovering from cardiac
surgery and were in need of high dependency care. We observed during our visit on 5
September 2012 that this was not reflected in the actual staffing level. Ward 32 was
staffed as a paediatric general ward and not as high dependency care.

Prior to our visit to Ward 32 we had requested a record from the trust of all the reported
incidents on Ward 32 from January 2012 until August 2012. We saw that staff had
reported incidents on several issues including medication errors, failure of equipment
and low and unsafe staffing levels. We looked at staffing levels on Ward 32 at during
our visit and our findings are referred to under outcome 13: staffing.

During our visit we focused on Ward 32, but we also spent time on the Paediatric
Intensive Care Unit (PICU) so we could understand the working relationship between
these two services. Nursing staff on PICU told us that relationships between PICU and
other units were good. They said they felt that they related particularly well with Ward
32, the outreach team and the neurosurgical unit in North Bristol. We were told by staff
on PICU that when a child was moved from PICU to Ward 32 there was a verbal
handover by phone and a second handover on the ward. A new assessment form was
then completed on Ward 32 to ensure consistency between wards.

Medical staff on PICU told us that there was a tight protocol for discharge from PICU
with inotrope infusions (drugs to keep the heart beating strongly). We were told they
were generally given through a central line, and rarely given on a general ward. The medical staff told us they currently believed that Ward 32 could cope with one child with inotropes, but not several. When we visited Ward 32 on 5 September 2012 we saw that the equivalent of high dependency care was being provided that day. We saw two older children who were being monitored on inotrope infusions.

On 5 September 2012 there were two children on inotropes and the junior doctors spoken with told us that "it was common place to have several children receiving inotrope infusions on Ward 32". Two registered nurses confirmed that high dependency care such as inotrope infusions were quite frequently used on Ward 32. One registered nurse said "parents can be very helpful with high dependency children as the child needs greater support. When dependency levels get high we have to record on a monitoring sheet".

We were told by the registered nurses that the four cubicles in front of the nurse’s station were for children with high needs as they could be more easily observed. All staff we spoke with were of the opinion that they offered "high dependency care" on Ward 32. Several members of staff told us that they needed dedicated high dependency beds as that was the care they were providing. They told us that "portable monitoring has helped us to care for children who need this support".

Staff told us that there was an active reporting culture on Ward 32. They said that the reporting of critical incidents was encouraged and there was no negative culture in relation to these. These anonymous reports were completed on line. The ward manager collated the reports and took them to a monthly governance meeting. At this event specific incidents were discussed and trends looked for. We were told that if there were any serious incidents they were taken further.

We found when we visited Ward 32 that the trust was not reducing the risk of people receiving unsafe or inappropriate care, treatment and support, due to high dependency care being delivered on Ward 32 without adequate staffing levels over a sustained period of time.

We observed a notice to prompt registered nurses to wear a red tabard when drawing up intravenous medication. Staff told us this was to ensure that other staff did not disturb the nurse in the medication room, in order to reduce the risk of making an error when drawing up intravenous medication. We were told that this practice was not for general use when the registered nurses were doing a drugs round.

We reviewed care records for children on Ward 32. We saw that there were plans in place for children's treatment and care. We saw that assessment and screening of children's needs had occurred and risk assessments were in place. These included risks of pressure ulcers, nutrition, mobility, and manual handling. There was also a nurse screening tool and a paediatric early warning assessment tool in place for each child which determined dependency levels.

We saw that observations were taken to monitor each child's condition and were documented within the paediatric early warning scoring chart. This was so that where a child's condition deteriorated, staff were alerted and action could be taken to rectify this. We saw that core care plans were in place to manage children's needs and these were updated when children were transferred from PICU. We observed some of the core
care plans were pre-printed. This information was recorded on a photocopied care plan form which was not clear in all the records we viewed. We also observed that this core care plan was basic in content. It contained a list of tasks and there was very little 'person centred' information to reflect the full needs of the child or the views and interventions of the parents. We also saw recorded on one care plan hand written comments about a baby being 'breast fed', but no detail of parents' views recorded.

The trust might like to note that this lack of detail about children's needs might make it more difficult for nursing staff that were new or temporary on the ward to fully understand the needs of the child or the parent. Although not seen during our visit, the trust has told us that a more detailed care plan is used if a child has a disability.

Health care assistants on Ward 32 told us that they looked at care plans for the children allocated to them, and that they were told by the registered nurses to ask if they needed to know something else about the child. One health care assistant said "all in all most parents seem satisfied with the care we provide".

We saw several recent 'thank you' cards in the office on Ward 32. We saw that these contained complimentary comments about the care and staff.

**Our judgement**
People who used the service were generally safe, but there were inherent risks to their outcome, health and wellbeing which the trust had been aware for a considerable period of time, but had not effectively addressed.

The provider was not meeting this standard for the regulated activity: treatment of disease, disorder and injury. We judged that this had a moderate impact on people using the service.
Outcome 13: Staffing

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement
The provider is non-compliant with Outcome 13: Staffing. We have judged that this has a major impact on people who use the service.

Our findings

What people who use the service experienced and told us
On the day of our visit to Ward 32, parents we spoke with did not report a staff shortage. They did however comment that the staff on Ward 32 were very busy. They also commented on staff shortages on other days they had been present on the ward.

One parent said that their child had never had to wait for feeds. They told us "if my child's named nurse was busy, then another nurse would take over. It is good team work. They all muck in together. Even after a 12 hour shift, one nurse still came to see me. They wanted to show me how to wind my baby another way. They had agreed to do that earlier in the shift but did not have time".

Another parent told us that "three to four weeks ago there was a bank nurse on duty for two nights as they were short of staff". They said that "this bank nurse was fine, but there was no continuity or communication. They did not understand our routine and woke us up when myself and child were settled for the night".

Two parents told us that "it was a difficult day on Monday for staffing". They told us the cardiac liaison nurse helped with medication administration as they were short staffed. Other parents generally commented that they had seen "lots of different staff around but we tend to see the same nurses when they are on".

Other evidence
Prior to our visit, concerns had been raised about the staffing levels on Ward 32. We looked at these concerns as part of our inspection.
Prior to our visit on 5 September 2012 we requested information from the trust about staffing levels on Ward 32. The trust provided us with a report ('CQC response: Staffing levels Ward 32'), sent by email on 20 August 2012, to confirm the nurse staffing level establishment on Ward 32 for 16 patients. This was four registered nurses and one health care assistant, Monday to Sunday day-time, that is, 7.30am - 8pm and three registered nurses and one health care assistant, Monday to Sunday night-time 8pm – 8am. We were told by the trust that this establishment did not include the ward sister being supervisory to practice.

The trust told us in the above report that the nurse staffing levels on Ward 32 had been determined using the Royal College of Nursing (RCN) guidance for clinical professionals and service managers 'Defining staffing levels for children's and young people's services (2003)'.

The RCN guidance 'Defining staffing levels for children's and young people's services' defined the nurse staffing levels for a general paediatric ward to be: Children under two years: one registered nurse to three children (both day and night), for age ranges over two years: during the day one registered nurse to four children and during the night one registered nurse to five children.

The trust told us that, as the Bristol Royal Hospital for Children did not have a designated high dependency unit, they had not made reference to the guidelines for staffing a designated high dependency unit. The RCN guidance 'Defining staffing levels for children and young people's services' defined the staffing levels for a high dependency unit to be: one registered nurse to two children (all ages) both day and night.

The trust told us in their report that they had recognised the risks associated with the lack of dedicated high dependency beds on Ward 32 or anywhere else in Bristol Royal Hospital for Children. The trust also sent us a copy of the draft 'operational policy for paediatric high dependency care at Bristol Royal Hospital for Children' dated 4 July 2012.

In this document the trust defined the purpose of high dependency care as 'to provide care to a child who may require closer observation and monitoring than is usually available on an ordinary children's ward'. The document set out a proposed approach for the location of paediatric high dependency care within the Bristol Royal Hospital for Children. This included the provision of a Medical High Dependency Unit and a Cardiac High Dependency Unit. This draft operational policy for the provision of the cardiac high dependency care stated that this care would be managed in Ward 32.

Attached to the report, 'CQC response: Staffing levels Ward 32' was a copy of a risk register form which had been completed on 9 February 2012. The risk register (risk number 1901), described the risk as 'unsustainability of current model of service delivery'. This risk register form recorded the following: 'Children with high dependent needs (including long term ventilation) are currently managed across the whole hospital, with the nursing staff supported by outreach team. Whilst this model is functional for a small number, when the ratio of highly dependant patients increases nursing resources are pulled from other areas in order to manage the clinical needs of individual patients on a daily basis. This results in an ad hoc system of delivering care to a cohort of patients who have high dependency requirements and who require a high
level of monitoring, intervention and nursing ratio. This results in frequent reduction in total bed base, reliance on temporary staffing and an inherent risk of compromised care'. The overall risk was rated as '3. High'.

The risk register described the 'Controls and Assurances' that were in place. These included, as part of workforce management, the use of temporary staff in response to clinical need and the 'daily deployment of practitioners within Outreach team with advanced clinical skills. Team limited to one person per 24/7 to cover hospital as a whole'. Controls also referred to the 'Frequent and formal processes for managing resources (beds and staff) across the hospital as a whole. Significant team working. Reliance on flexibility in deployment of resources'.

The risk register referred to the assessment of controls as 'medium' and the residual risk classification of 'moderate'. The target was to reduce the risk rating from '3 High' to '1 Low'. The action to be taken by the trust was the 'Submission of formal bid through commissioning and planning process to provide a defined High Dependent Unit'. A draft operational policy for paediatric high dependency care at Bristol Royal Hospital for Children had been developed although the outcome of the bid was not yet known. This meant that the trust continued to operate a model of service delivery which they have described as 'unsustainable'.

The trust also told us in their report 'CQC response: Staffing levels Ward 32' (High dependency care section) that 'high dependency care is on the Women's and Children's risk register and is graded as one of the Division's top risks. As a result of this grading, the risk has an appointed member of the Trust Executive team as the owner". The risk register form was dated 9 February 2012 and the target date for action recorded as 1 October 2012 to submit a formal bid to provide a High Dependent Unit.

In the same report ('CQC response: Staffing levels Ward 32') we were informed by the trust that 'There have been concerns raised from the clinical team regarding the levels of acuity experienced at times on Ward 32'.

Furthermore, the trust also sent us data attached to their report which showed unfilled registered nurse shifts for the period January 2012 to July 2012 on Ward 32. These unfilled shifts for registered nurses ranged from 12 to 30 a month and unfilled health care assistant shifts ranged from 3 to 15 a month for the same period. The data did not inform us if the shifts were full day or half day.

Prior to our visit on 5 September 2012 we also asked the trust to send us a copy of the staffing rotas for Ward 32 from January – August 2012. On 6 September 2012 we received staffing rotas up until 9 August 2012.

We requested to see records of incidents reported by the staff on Ward 32 to the trust from January 2012 until August 2012. The incident reports we received on 20 August 2012 showed that staff had reported their concerns about unsafe staffing levels 10 times in a seven month period.

We visited the Paediatric Intensive Care Unit (PICU) so we could see the contrast in the working practices of staff on PICU with the staff on Ward 32. The registered nurses on PICU told us about the paediatric outreach team which visited children in all the wards
in the hospital, including Ward 32. We were informed that there was a protocol as to their deployment. They visited all PICU discharges for a period of two days and were called for other children in the hospital who are scoring high on the physiological scores. These were nurse practitioners who were generally registered nurses who worked on PICU. One of these nurse practitioners was on duty every day for the whole hospital.

One registered nurse told us that they could be "stretched" on PICU if there was a group of new nurse starters which the established nurses have to mentor while doing their own work at the same time. Nursing staff told us that on the whole staffing levels were well managed on PICU.

The registered nurses told us that children’s transfers out of PICU were "generally very smooth and very well planned". They told us that "occasionally when PICU was quiet they had to help out on the wards such as 32. One registered nurse said that they found Ward 32 was "a very busy ward, and therefore stressful".

On Ward 32 we met with the registered nurse in charge and one of the senior managers from the trust. We also spoke with the registered nurses and health care assistants on duty who gave us examples of when the staffing levels had had an impact on the care of the children and parents.

When we arrived on Ward 32 at 9am there were four registered nurses on duty, including one from another ward who was providing cover for a bank staff nurse who had cancelled their duty that day. There was also one health care assistant and another health care assistant who was new to Ward 32 and supernumerary. We were told that all the staff on duty when we arrived on Ward 32 had been on duty since 7.30am and would be finishing duty at 8pm.

Staff told us that this was a "management day" and the ward sister usually had one management day each week on a Wednesday, but was on leave on the day we visited. The trust had told us that the staffing establishment did not include the ward sister being supervisory to practice. From the staff rotas we were given, we saw that the ward sister was on occasions included as part of the registered nurse compliment.

Staff told us that following a review of staffing on Ward 32 in March 2012 the majority of day staff chose to work a long day from 7.30am - 8pm, Monday to Sunday. However, some staff chose to work a mixture of shifts, which could include 7.30am - 2pm and 1.30pm - 8pm. The night duty was from 7.30pm – 8am, Monday to Sunday. A registered nurse confirmed that the staffing level on Ward 32 for 16 children was four registered nurses and one health care assistant, Monday to Sunday day-time, that is, 7.30am - 8pm and three registered nurses and one health care assistant, Monday to Sunday night-time 7.30pm – 8am.

This meant that during the day shift the staffing ratio on Ward 32 would be one registered nurse to four children and during the night there would be one registered nurse to 5.3 children. Therefore according to these guidelines the staffing levels on Ward 32 were set at the level for a general ward for children over two years of age and not staffed at the levels stated in the RCN guidance for children under two years of age or for children who required high dependency care.
During our visit on 5 September 2012 we asked for the staff rotas for the four weeks commencing 12 August 2012. These rotas showed a number of occasions when the number of registered nurses on duty was below the trust's planned number. There were nine early shifts i.e. 7.30am - 2pm when the staffing level was three registered nurses and one health care assistant. On a number of late shifts i.e. 1.30pm - 8pm there were recorded to be two registered nurses and one health care assistant on duty.

During our visit to Ward 32 we asked a senior manager about how the gaps in the staffing rota are filled. The senior manager told us "if the bank or agency cannot provide a registered nurse or health care assistant, then the Bristol Royal Hospital for Children site team, who over see staffing on wards, must have another plan. They know the pressures in the hospital and will try to free somebody up. They may close beds to admissions to free staff up". This senior manager shared their concerns about the length of time that this matter had been on the risk register and the continued pressures on staffing.

We spoke with five registered nurses, two health care assistants and two doctors on Ward 32 during our visit on 5 September. They all had concerns relating to the staffing of the ward; the staffing levels were described to us in terms such as "inadequate" and "low". Staff said that their concerns had been raised with managers and that staffing levels had been inadequate for the last 18 months. We were given examples of when staffing levels had fallen below the established level.

Staff told us about occasions which had caused them concern and had resulted in the completion of an incident form. One member of staff told us “it was difficult to fill the gaps in the rota last week. On 28 August 2012 there were only 3 registered nurses for the night duty. There should have been four staff in total including a health care assistant. There were 16 children, some of whom were under two years old. It was the last week of the school holiday and it was difficult to fill. The bank, agency and hospital were all contacted, but nobody was available. We just get on with it.”

Staff also told us that the night duty should be covered by three registered nurses and one health care assistant, but they said that this did not always happen.

A doctor told us of one shift earlier in the week where two of the nurses had not been cardiac trained. They said that this was frequently the case and told us" on paper there might be the correct compliment of staff; but they do not necessarily have the right skill mix".

Staff told us about the impact that the current staffing levels were having on the care and service being provided. A registered nurse told us “checks sometimes do not get done. I feel we have not progressed care”. Another staff member commented “observations are reduced” and another that “things came to a head several weeks ago when there were a lot of complaints about Ward 32 which the ward staff directed to the patient liaison office” and another that “because of the overstretched nature of Ward 32 there was a lack of time to communicate properly with parents".
Our judgement
There was not sufficient qualified, skilled and experienced staff to meet people's needs. The provider was not meeting this standard for the regulated activity: treatment of disease, disorder and injury. We judged that this had a major impact on people using the service.
Outcome 14:
Supporting workers

What the outcome says
This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

| Our judgement |
|---------------|--------------------------------------------------|
| The provider is non-compliant with Outcome 14: Supporting workers. We have judged that this has a moderate impact on people who use the service. |

<table>
<thead>
<tr>
<th>Our findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
</tr>
<tr>
<td>People we spoke with on Ward 32 told us they felt staff were knowledgeable about the treatment and care they were providing.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other evidence</th>
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<tbody>
<tr>
<td>Prior to our visit to Ward 32 we requested information from the trust about the qualifications, skills and experience of all the staff working on Ward 32. The information we received from the trust on 20 August 2012 informed us that all registered nurses who worked on Ward 32 were paediatric trained. We were also sent a list of the additional qualifications / courses attended by the permanent registered nurses on Ward 32. We received no information about what qualifications, skills and experience or specific training the health care assistants working on the ward had received.</td>
</tr>
</tbody>
</table>

During our visit to Ward 32 we spoke with five registered nurses, two health care assistants and two doctors on the ward. We found that not all of the staff received appropriate professional development to care for the children admitted to Ward 32.

Several members of staff expressed their concerns about the lack of specialist training for doctors, registered nurses and health care assistants to work with children on Ward 32.

One doctor told us "There is no formal induction for the trainee cardiology paediatricians and no attention is paid to the development needs of these registrars". Another doctor told us that they had had two days of trust induction, but no paediatric or cardiological induction. They told us that they had organised paediatric life support
training themselves and that there was a trust relearning package that they were working through which was mandatory training including hand washing, blood transfusion, safe insulin prescribing and antibiotic prescribing.

Some of the registered nurses we spoke with on Ward 32 told us that they received mandatory training, but more specialist training was sometimes difficult to attend as it was in London or one of the other cardiac centres and did not do not fit in with part time working and shift patterns.

We were told about the 'high dependency care' training that was available through the trust which some of the registered nurses had attended in July 2012. We heard that other staff were booked on this course in May 2013.

Some registered nurses we spoke with on Ward 32 told us that sometimes registered nurses and health care assistants were not able to attend teaching sessions or study days in the hospital due to workload. One registered nurse said "staff will get pulled off training if staffing levels are low".

We also spoke with registered nurses who were new to the Ward 32 and health care assistants. We were told that Ward 32 is called the "cardiac ward" and is known to be "quite a technical ward".

One member of staff said "It is quite a challenge, but if you are new you are given the lower dependency children. There is no preparation for working on Ward 32, but you are shown around as part of introduction to the ward. The permanent staff are very helpful. They wouldn't give me any jobs I wasn't happy with".

Following our visit to Ward 32 on 5 September 2012 we requested additional information about staff training because concerns were raised during our visit by registered nurses and doctors that not all staff who worked on Ward 32 had experience of paediatric cardiac care or paediatric high dependency care.

This gap in experience was confirmed in the information we received from the trust on the 18 September 2012. We saw from the list of training that we received that some registered nurses had completed a paediatric cardiac course and some had completed a paediatric high dependency course, but very few had completed both. The trust told us that where such standards are described nationally – such as in paediatric or neonatal intensive care – the standard is set at 70% of staff able to demonstrate specialist post-registration education intensive care. We were also told that all nurses working on Ward 32 had undertaken Paediatric Life Support training which included training in recognising and responding to the 'deteriorating child'.

The report the trust sent us on 18 September 2012 told us that 38.5% of registered nurses on Ward 32 had not attended a paediatric cardiac course and 62.5% had not attended a specific paediatric high dependency course. This report also identified that health care assistants working on Ward 32 had not received a children's specific induction for caring for children who were admitted to Ward 32.

Registered nurse and health care assistants we spoke with told us they had received an annual appraisal and that any ongoing issues from their appraisal would be followed up during the year.
All registered nurses and health care assistants we spoke with felt they were supported in their role. They told us that the Ward Manager had an open door policy and they were able to have discussions and raise concerns when necessary, but there were time constraints on this support due to staff shortages. We were told that there was no formal supervision processes in place on Ward 32 for registered nurses or health care assistants.

Our judgement
People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider was not meeting this standard for the regulated activity: treatment of disease, disorder and injury. We judged that this had a moderate impact on people using the service.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities)</td>
<td>Outcome 04: Care and welfare of people who use services</td>
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<td></td>
<td>Regulations 2010</td>
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<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
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<tr>
<td></td>
<td>People who used the service were generally safe,</td>
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<td></td>
<td>but there were inherent risks to their outcome,</td>
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<td></td>
<td>health and wellbeing which the trust had been</td>
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<td></td>
<td>aware for a considerable period of time, but had</td>
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<tr>
<td></td>
<td>not effectively addressed.</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities)</td>
<td>Outcome 14: Supporting workers</td>
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<tr>
<td></td>
<td>Regulations 2010</td>
<td></td>
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<tr>
<td></td>
<td><strong>How the regulation is not being met:</strong></td>
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<tr>
<td></td>
<td>People were not cared for by staff who were</td>
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<td></td>
<td>supported to deliver care and treatment safely</td>
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<td></td>
<td>and to an appropriate standard.</td>
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The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.
CQC should be informed in writing when these compliance actions are complete.
Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

### Enforcement action taken

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 13: Staffing</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>How the regulation or section is not being met:</th>
<th>Registered manager:</th>
<th>To be met by:</th>
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<tbody>
<tr>
<td>There was not sufficient qualified, skilled and experienced staff to meet people's needs</td>
<td></td>
<td>18 October 2012</td>
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</table>
What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called Guidance about compliance: Essential standards of quality and safety.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

- **Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

- **Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
### Information for the reader

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>The general public</td>
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<tr>
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<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
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<tr>
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<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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<td>Postal address</td>
<td>Care Quality Commission</td>
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<td></td>
<td>Citygate</td>
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