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RECORDED DELIVERY / BY HAND / BY EMAIL

For the attention of the Chief Executive Officer

University Hospitals Bristol NHS Foundation Trust
Marlborough Street
Bristol
BS1 3NU

26 September 2012
Reference Number: RA7
The Care Quality Commission
The Health and Social Care Act 2008

Dear Sir or Madam

WARNING NOTICE:

This warning notice relates to your registration to carry on the regulated activity treatment of disease, disorder and injury at the following location:

University Hospitals Bristol Main Site
Bristol Royal Infirmary
Upper Maudlin Street
Bristol
BS2 8HW

We are notifying you that you are failing to comply with relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (the Regulated Activities Regulations 2010)

The Regulated Activities Regulations 2010

You are failing to comply with Regulation 22, Staffing, which states:

22. In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably registered, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

Why you are failing to comply with this regulation:

1. On 5 September 2012, Sandra Gibson and Malcolm Kippax (Compliance Inspectors) of the Care Quality Commission and Professor Danny Keenan,

(National Clinical Advisor - consultant cardiothoracic surgeon) for the Care Quality Commission, visited Ward 32 and the Paediatric Intensive Care Unit (PICU) at Bristol Royal Children's Hospital, part of the University Hospitals Bristol Main Site.

2. Ward 32 is a 19 bedded ward (funded and open for 16 beds) predominantly dedicated to the care of children from 0 -16+ with a primary cardiac diagnosis. Children are cared for with a spectrum of treatments ranging from medical management, day case/short stay interventions, and pre/postoperative cardiac surgery. Children are treated from the South West region and South/West Wales regions as part of an established cardiac network. On the day of our visit there were 16 patients on Ward 32.

3. Prior to our visit on 5 September 2012, concerns had been raised with the Care Quality Commission on 26 July 2012 by two families about the care and inadequate staffing levels on Ward 32. The trust also received formal complaints from these two families. We were told by the trust that these complaints were being investigated.

4. Prior to our visit on 5 September 2012 we requested information from the trust about staffing levels on Ward 32. The trust provided the Care Quality Commission with a report ('CQC response: Staffing levels ward 32'), sent by email on 20 August 2012, to confirm that 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 i.e. 7.30 am - 8 pm 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 who was supernumerary.

5. 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)'.

6. 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 patients (both day and night), for age ranges over two years: during the day one registered nurse to four patients and during the night one registered nurse to five patients.

7. 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.

8. The trust told us in their report ('CQC response: Staffing levels ward 32'), we received by email on 20 August 2012, that they had recognised the risks associated with the lack of dedicated high dependency beds on Ward 32 or anywhere else in Bristol Royal Children's Hospital. The trust also

sent us a copy of the draft 'operational policy for paediatric high dependency care at Bristol Royal Children's Hospital' dated 4 July 2012.

9. In this document the trust defines 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 also outlines the need for both a dedicated medical high dependency unit and a dedicated cardiac high dependency unit within Bristol Royal Children's Hospital. This draft operational policy for provision of the cardiac high dependency care states that this care would be managed in ward 32.

10. Attached to the ('CQC response: Staffing levels ward 32') report was a copy of a risk register form which had been completed on 9 February 2012. The risk number 1901 described the risk as 'unsustainability of current model of service delivery'. This risk register form recorded the following; "children with high dependant needs (including long term ventilation) are currently managed across the whole hospital, with the nursing staff supported by outreach team. Whilst this number 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. Controls and assurances were put in place with regard to workforce management relating to utilising temporary staff and use of an outreach practitioner to cover the hospital as a whole.

11. 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.

12. Furthermore, the trust also sent us data attached to their report (CQC response : Staffing levels Ward 32), on 20 August 2012, 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.

13. We were informed by the trust in the report 'CQC response: Staffing levels ward 32' (section on Issues relating to Ward 32 Bristol Children's Hospital), sent to us on August 2012, that "there had been concerns raised from the

clinical team regarding the levels of ‘acuity’ i.e. activity experienced at times on Ward 32”.

14. 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 sent us staffing rotas up until 9 August 2012.

15. 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.

16. 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.

17. 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.

18. 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 thirteen times in a seven month period. We reviewed a number of incidents reported:

19. This incident report recorded that on 15 April 2012 unsafe staffing levels were reported on Ward 32 for the early (day) shift. The record stated “Unsafe staffing levels on ward for early shift .3 x trained and 1 untrained. This was the second shift for one of the trained members of staff after long term sickness (absence of 3 month period, and requiring support). 2x patients on Vapotherm,I patient on inotropes, I patient requiring hourly neuro obs, all of whom require hourly observations. I patient with large pleural effusion awaiting surgical drain insertion and requiring nurse escort to X-ray, 2 other patients unwell and deteriorated overnight. 1 patient on Vapotherm of 8L and 100% oxygen due to desaturations to 40-50% and pyrexial to 39 degrees. Unable to achieve hourly observations and fluid

recordings. Unable to answer door to parents which in turn increased parental anxiety. Drugs and feeds given late". We checked the staff rota and the staff experience list about this shift, and noted that only registered nurse had training in paediatric cardiac care and paediatric high dependency care.

20. That same day, 15 April 2012, it was also reported that the night shift had 'inappropriate and unsafe staffing levels' on Ward 32 due to sickness. It was recorded that there was "1 trained nurse and I untrained rostered to work. Already 1x trained bank shift requested –unable to fill and out to agency". We checked the staff rota about this shift. We observed that three registered nurses and one health care assistant had been rostered to work that night shift, but it was unclear who had worked that evening and what specialist training they had received.

21. Two more recent incidents reported included one incident that was reported on the day shift of 9 July 2012 by an unnamed registered nurse. This registered nurse recorded that "on this shift there was myself, one other trained nurse who works on Ward 32, with a health care assistant, and a bank nurse. The high level of dependency patients on the ward was very significant, with four admissions, three of which were medical patients and one was a newly diagnosed cardiac patient. There was a baby on the ward who had only been on the Ward 2 - 3 hours as a transfer from PICU who required a review by medical staff and outreach due to increasing respiratory distress at the start of the shift. There were five "E4" cardiac patients already on the ward and in total there were eight children on intravenous medication". The report also recorded that there was an acutely ill child and three babies on the ward. (We were informed that "E4" is a Paediatric Early Warning Score for High dependency care).

22. This incident report did not record the number of patients on Ward 32, but it did show that there were several children with high dependency needs and three children under two years. We also checked the staff rota and observed that there was only one permanent registered nurse working that night with paediatric cardiac experience and paediatric high dependency experience.

23. It was recorded in a further incident report that the night shift on 11 July 2012 was 'very busy' and registered nurses found the workload 'tough'. On duty were two registered nurses, a health care assistant and a bank registered nurse who had only occasionally worked on Ward 32. The report stated that seven out of 12 children had high dependency needs.

24. This incident report did not record the number of patients on Ward 32, but it did show that there were seven children out of 12 with high dependency needs. We also checked the staff rota and we could not confirm if the registered nurse had paediatric cardiac experience and paediatric high dependency experience.

25. Following the concerns raised by the two families and having reviewed the information from the trust Sandra Gibson and Malcolm Kippax visited Ward 32 on 5 September 2012 and 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 an impacted on the care of the children and parents.

26. When we arrived on Ward 32 at 9am we asked who was on duty that day. We were told by registered nurse (B), that the ward sister was on leave of absence that day. 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. Registered nurse (B) told us that all the staff on duty when we arrived on Ward 32 had been on duty since 7.30 am and would be finishing duty at 8 pm.

27. We were told by registered nurse (B) that the ward sister had been due to be supernumerary to the staffing level on 5 September 2012. We were told that this was a "Management day" and the ward manager usually had one management day each week on a Wednesday. However contrary to the information we had received from the trust about staffing levels we were told that the ward sister was not supernumerary every shift but was included in the staffing numbers on most shifts, each week.

28. Registered nurse (B) 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 7.30 am - 8 pm, Monday to Sunday. However, some staff chose to work a mixture of shifts, which could include 7.30 am - 2 pm and 1.30 pm - 8 pm. The night duty was from 8.00am – 8pm, Monday to Sunday. Registered nurse (B) confirmed that the staffing level on ward 32 for 16 patients was four registered nurses and one health care assistant, Monday to Sunday day-time i.e. 7.30 am - 8 pm and three registered nurses and one healthcare assistant, Monday to Sunday night-time 8pm – 8am.

29. This meant that during the day shift the staffing ratio on ward 32 would be one registered nurse to four patients and during the night there would be one registered nurse to 5.3 patients. 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.

30. 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 Bristol Children's Hospital 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".

However, they also stated that “the trust have got to the point where this situation cannot be managed”. This senior manager told us “it is now on the risk register and has been for six to nine months. Staffing problems are increasing and we can only absorb to a certain level. We all acknowledge it is not sustainable.”

31. When we visited Ward 32 on 5 September 2012 we saw that high dependency care was being provided that day. We saw two older children who were being monitored on inotropes infusions. We were told by registered nurse B that the staffing ratio for inotropes infusions was on registered nurse to three patients. We were informed that rooms 16, 17, 18, and 19 were for children with high needs. Registered nurse (B) told us that staff had been told that they should not use the term “high dependency care” as it had been misleading for parents. We also saw two children under two years on the ward. Doctor (C) told Professor Danny Keenan that Ward 32 can cope with one child on inotropes but not several. On the 5 September there were two children on inotropes and the junior doctors spoken with told Professor Danny Keenan that “it was common place to have several patients receiving inotropes infusions on Ward 32”. This information was confirmed by registered nurse (C) who told us “Inotropes infusions are used quite frequently on this ward.

32. 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”. A doctor (A) said that the staffing levels on Ward 32 “were not right” and there was “quite a void between Ward 32 and PICU when it came to staffing”.

33. Staff said that their concerns had been raised with managers. One registered nurse (C) told us they were concerned from a professional point of view and had first raised concerns with managers over a year ago. Registered nurse (B) said that staffing levels had been inadequate for the last 18 months and commented “we have tried to prove the point to senior management”. A third registered nurse (D) told us that the senior staff have serious concerns about how they can manage the ward with “poor staffing levels”. A fourth registered nurse (E) said that they felt frustrated and “professionally vulnerable” at times.

34. Staff told us about occasions which had caused them concern and had resulted in the completion of an incident form. Registered nurse (B) said “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 patients, 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.”

35. Another registered nurse (E) 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.

36. The health care assistants we spoke with (A and B) also told us about variations in staffing levels. They told us that the staffing during the day should be four registered nurses and one health care assistant, but they said that this level of cover was not always in place. One health care assistant (A) commented "some weeks are worse than others. It's an on going situation".

37. A health care assistant (B) said that they had been concerned about the staffing on the ward earlier in the week when a day shift had started with only three registered nurses, two of whom had come from another ward to provide cover. A doctor (B) told us that two of the nurses on this shift 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".

38. Staff told us about the impact that the current staffing levels were having on the care and service being provided. A registered nurse (E) told us "checks sometimes do not get done. I feel we have not progressed care". A health care assistant (A) commented "observations are reduced". Doctor (B) told Professor Keenan 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". Doctor (B) told Professor Keenan that "because of the overstretched nature of Ward 32 there was not enough time for staff to communicate with families

39. Staff told us how they tried to alleviate staffing difficulties, for example by working flexibly and taking fewer breaks. A registered nurse (C) told us that the children's needs fluctuated, but allocations were arranged so that the less experienced staff cared for those children who had a lower level of dependency. A health care assistant (A) said that there were risks with the allocation system when the staffing level reduced as they were given a higher number of children to care for.

40. A registered nurse (E) told us that staffing levels fluctuated due to sickness, maternity and other leave. A number of the staff we met with said they were new to the ward or they usually worked in another ward. They told us that the experienced staff did their best to help them and to answer any questions, but they were aware that this was an additional task for staff who were already busy with their own work.

41. Professor Keenan visited the Paediatric Intensive Care Unit (PICU). Registered nurse (A) told Professor Keenan that "occasionally when PICU was quiet they had to help out on the wards such as 32. Registered nurse (A) said they found Ward 32 was "a very busy ward, and therefore stressful".

42. 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. 7.30 am - 2 pm when the staffing level was three registered nurses and one health care assistant. On a number of late shifts i.e. 1.30 pm - 8 pm there were recorded to be two registered nurses and one health care assistant on duty.

43. Staff had told us about staff shortages on 3 September 2012 and this had also been mentioned by some parents. The rota for this day showed there had been two registered nurses and one health care assistant working on the early shift. The staff and parents we spoke with told us that the cardiac liaison nurse had assisted on Ward 32 as there were staff shortages that day.

44. We checked the names on the staff rota 3 September 2012 against the list of additional qualifications and training. The ward manager was on duty and had experience of paediatric critical care and paediatric cardiac care. Another registered nurse had paediatric cardiac care training booked for May 2013 but had no high dependency care experience. The third registered nurse was not included on the list we had been sent.

45. We also checked the staff rota for the 16 August 2012 as we observed that the late shift 1.30pm - 8 pm recorded that three registered nurses were working instead of the established staffing ratio of four registered nurses in total. There was no information to confirm if bank, agency staff or a redeployed nurse had been found to cover that shift.

46. We checked the staff rota for 16 August 2012 against the list of additional qualifications and training the registered nurses had completed and observed that only one member of staff on duty had paediatric cardiac experience, but had not completed any paediatric high dependency care training and the other two registered nurses names were not recorded on the additional qualifications and training list and therefore there was no information to confirm that they had the appropriate qualifications, skills and experience to care for patients on Ward 32 .

47. Following our visit on 5 September 2012 we asked to see the children's governance committee meeting minutes from April 2012 to August 2012. We saw from the minutes dated 5 April 2012 that there had been a 'high amount of pressure' over the last month on PICU and Ward 32. The minutes told us that "there had been a number of sick children being moved back to the wards from PICU which had led to a higher number of incidents being reported. This has been due to a high demand on PICU beds. "The staffing levels are right for normal patient dependency. The higher dependency levels are still to be decided. These concerns have been raised. Ward 32 has vacancies available which can hopefully go to advert quickly. A staffing risk assessment for ward 32 was completed

following a high risk incident in October 2010 and has been ongoing since that date."

48. The Children's governance committee meeting minutes dated 5 April 2012 referred to the Women's and Children's risk register entry on "high dependency care" recorded on 9 February 2012. This risk had been graded as one of the Women's and Children's Division's top risks.

49. 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 Ward 32 was admitting 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 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.

50. The information from the trust therefore demonstrated that they had identified that Ward 32 cared for high dependency patients, but the staffing levels did not reflect high dependency care. Therefore the trust had identified the risks of providing high dependency care on a general ward, but had taken no further steps to ensure they reduced the risks to those patients.

51. As evidenced above, the trust has failed to take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff on ward 32. We found that on a number of shifts between April and September 2012 staffing levels on Ward 32 fell below your planned levels and some staff did not have the appropriate experience to care for patients with high dependency needs. When staffing levels fell below the planned number, the staff we spoke with on 5 September 2012 told us observations were reduced, and care was not progressed. This was confirmed in the incident reports the trust sent us on 20 August 2012 where staff reported that they were "unable to achieve hourly observations and fluid recordings. Unable to answer door to parents which in turn increased parental anxiety. Drugs and feeds given late". Patients have been put at risk due to insufficient staffing levels.

You are required to become compliant with Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 18 October 2012.

Please note: if you fail to achieve compliance with the relevant requirement within date 18 October 2012 we may take further action.

We will publish a summary of this warning notice. If you do not agree with this, you can make representations to us in writing within 5 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number (above).

If you have any questions about this notice, you can:

a) Contact your local inspector or assessor, or
b) Contact our National Contact Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Sue Burn
Compliance Manager

This notice is served under Section 29 of the Health and Social Care Act 2008.