Care Quality Commission

Royal Cornwall Hospitals NHS Trust

West Cornwall Hospital

Quality Report

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Date of inspection visit: 21 and 25 January 2014
Date of publication: 27/03/2014

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

Ratings

Overall rating for this hospital	Good
Minor injuries unit	Good
Medical care	Good
Surgery	Good
Outpatients	Good

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 3

The five questions we ask about hospitals and what we found 4

What we found about each of the main services in the hospital 6

What people who use the hospital say 7

Areas for improvement 7

Good practice 7

Detailed findings from this inspection

Our inspection team 8

Background to West Cornwall Hospital 8

Why we carried out this inspection 8

How we carried out this inspection 8

Findings by main service 10

Action we have told the provider to take 31

Summary of findings

Overall summary

West Cornwall Hospital is one of three acute hospital locations run by Royal Cornwall Hospitals NHS Trust. It provides medical inpatient care for older people and day case surgery, as well as diagnostic and therapy services and a wide range of outpatient clinics. The hospital has a 24 hour urgent care centre which run by the trust and is a type 3 doctor led service. This type of service is more comprehensive than a minor injury unit,- but not as extensive as an Emergency Department; for example, patients with major trauma injuries or suffering a heart attack would be taken directly to Treliske Hospital.

The hospital is registered to provide: Assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures; surgical procedures; treatment of disease, disorder or injury, termination of pregnancies and family planning.

To carry out this review of acute services we spoke to patients and those who cared, or spoke for them. Patients and carers were able to talk with us, or write to us before, during and after our visit. We listened to all these people and read what they said. We analysed information we held about the hospital and information from stakeholders and commissioners of services. People came to our two listening events in Truro and Penzance to share their experiences. To complete the review we visited the hospital over two half days, with specialists and experts. We spoke to 12 patients and 23 staff from all areas of the hospital during our visits.

Patients received safe care and were protected from risks. The hospital was clean and infection rates low. Patients care and treatment was effective and was planned and delivered in line with legislation and best practice. There were some concerns relating to the timeliness of record keeping which risked a patients care or condition deteriorating without the written evidence for staff to compare the patient's signs and symptoms. Patient dignity could be compromised in the recovery ward. Most staff had received an appraisal in the last year and commented positively on the support they received; however, clinical supervision for nurses was under developed. (Clinical supervision is an opportunity for practising professionals to discuss and review their practice in order to improve their care.)

Patient needs were assessed, and care planned and delivered to meet these needs. The discharge liaison nurse had made a positive impact on the planning and timeliness of discharges; however, some patients had their discharge delayed due to the availability of appropriate support packages for care at home or care home beds.

The hospital was well-led; in particular staff spoke highly of the matron and divisional manager. Communication with the wider trust had also improved. Governance arrangements were appropriate.

Information on how each area in the hospital was doing and feedback on patient experiences was displayed through the hospital, demonstrating an open culture.

Staffing

There was sufficient staffing capacity, including an appropriate skill mix to enable the effective delivery of care and treatment.

Cleanliness and infection control

The hospital was clean, with information such as the use of hand gel clearly displayed alongside the gel dispensers throughout the hospital. Infection rates were low.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Good

Patients received safe care and were protected from risks. Incidents were reported appropriately, with evidence of learning from these to improve care; with examples of learning, both from incidents that had happened within the hospital (for example, falls and pressure ulcers), as well as those that had occurred in other parts of the trust (for example, 'never events' in theatre - these are largely preventable patient safety incidents that should not occur). Patient records were not kept up to date in a timely manner. This posed a risk to patients, as it was not always clear whether or not care had been given, what time the care had been given and as documentation was signed retrospectively, what time it was signed. The hospital was clean and infection rates were low.

Are services effective?

Good

Patient care and treatment was planned and delivered in line with legislation and best practice. Audits were undertaken to monitor care and outcomes, and action plans implemented where required to improve care. Appropriate equipment was available. Staff had undertaken appropriate mandatory training and most had received an appraisal. Clinical supervision was not well developed.

Are services caring?

Good

Patients were treated with dignity, respect and compassion. The vast majority of comments from patients about their care were positive. Patients were involved in their care and could make decision on an informed basis. There was a risk of dignity being compromised in the theatre recovery area, where there were no curtains at a window between the recovery area and the corridor, which could compromise patient privacy.

Are services responsive to people's needs?

Good

Patient needs were assessed and care planned and delivered to meet these needs. Care for patients with dementia was good, with consideration given as to making a hospital ward environment as suitable as possible for patients with dementia. The discharge liaison nurse had made a positive impact on the planning and timeliness of discharges; however, some patients were delayed in their discharge due to the availability of appropriate support packages for care at home or care home beds.

Are services well-led?

Good

The hospital was well-led. The governance arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and problems detected, understood and

addressed; the matron and divisional manager were visible in the wards and departments, and non-executives visited the areas with feedback to staff. Many staff commented that they were proud to work at the hospital.

In each area feedback was displayed to patients, visitors and staff on how the area was performing and of patient experiences. Patient views and experiences and key performance information drove improvements and publicised good care where relevant.

Summary of findings

What we found about each of the main services in the hospital

Minor injuries unit

Good

The urgent care centre was a type 3 service. This means that it is a doctor led service, and this is combined with an urgent care service provision with GP cover. Patients received safe and effective care. There were sufficient numbers of staff, with appropriate qualifications, skills and experience to ensure that patient needs were met. The vast majority of patients were seen within four hours and additional resources were brought in to manage the higher demand for the service in the summer months. The centre was well-led; staff were well supported and were confident in raising issues with senior managers

Medical care (including older people's care)

Good

Patients received safe care. Staff were aware of how and when to report incidents; they got feedback on these and learnt lessons to improve patient care. Care was delivered in line with national standards and evidence-based practice; however, this was not always documented in a timely manner. There were sufficient staff with appropriate skills, knowledge and experience. A discharge liaison nurse position had been recently introduced and this was having a positive impact; however, there were patients whose discharge was being delayed due to a lack of appropriate support packages for care at home, and limited care home beds. There was good awareness of the Mental Capacity Act 2005. Staff spoke very highly of the matron and the hospital was well-led.

Surgery

Good

Patients received safe and effective care. Staff were aware of how and when to report incidents, they got feedback on these and learnt lessons to improve patient care. Care was delivered in line with national standards and evidence-based practice. There was good awareness of the Mental Capacity Act 2005. Staff were caring and compassionate, although, as there were no curtains at the windows, the patients' privacy and dignity could be compromised.

Outpatients

Good

Patients received safe and effective care delivered by appropriate numbers of staff with relevant qualifications for their roles. The department was well-led. The outpatients department was located in an old part of the hospital with narrow corridors and small rooms. The environment was not well suited to the delivery of modern day healthcare; however, it had been recently refurbished and significant effort made to make it user-friendly, with colour coded areas to help patients find their way around.

Summary of findings

What people who use the hospital say

In the 2012 adults inpatient survey the trust performed about the same as other trusts across all areas. In one area relevant to this hospital, "The availability of hand gels for patients and visitors", it performed worse than other trusts, and in one area, "Did you feel threatened during your stay in hospital by other patients or visitors?" it performed better than other trusts.

The NHS Choices website provides information specific to this hospital site. It shows that the hospital had been rated five stars out of five stars, and all but two of the 37 comments posted in the last 12 months were positive.

In the Friends and Family test, out of 35 responses 34 of patients asked were either likely or extremely likely to recommend the ward they stayed in to friends or family.

Areas for improvement

Action the hospital MUST take to improve

- Patient records did not accurately reflect the care given, the time the care was given, or the time documentation was completed if this occurred retrospectively.

Action the hospital COULD take to improve

- Clinical supervision was not well developed.
- Patients' privacy and dignity was compromised in the recovery ward due to the lack of curtains or screens at the window into recovery.
- Due to its layout, the outpatients department was not well suited to modern day healthcare.

Good practice

Our inspection team highlighted the following areas of good practice:

- The vast majority of comments received from patients were very positive about the care they had received in the hospital.
- There was evidence of learning from incidents to improve patient care.
- Staff were proud of the care and treatment they provided to patients.
- Multidisciplinary working was very good in all wards and departments.
- The introduction of the discharge liaison nurse was improving the co-ordination of discharges for patients.
- Staff felt well supported by the local managers.
- Patients were involved in their care and decision-making.
- Patients had sufficient information on which to make an informed consent.
- Extra resources were planned for the summer months in the urgent care centre, to meet the demands of the increased population of holiday makers.

West Cornwall Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Sheila Shribman, recently retired National Clinical Director for Children, Young People and Maternity at the Department of Health, and consultant paediatrician. Non-executive director at Guy's and St Thomas' NHS Foundation Trust.

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission (CQC).

The team included CQC inspectors and a variety of specialists: an advanced nurse practitioner, a specialist advisor for theatres and an expert by experience.

Background to West Cornwall Hospital

West Cornwall Hospital is one of three acute hospital locations run by Royal Cornwall Hospitals NHS Trust. It provides in-patient and day care treatments and surgery, as well as diagnostic and therapy services and a wide range of outpatient clinics. The hospital has a 24 hour Urgent Care Centre.

Since its registration with the Care Quality Commission West Cornwall has been inspected three times in 2011, 2012 and 2013. On all inspections it was meeting all the standards inspected.

During this inspection we visited both medical wards, the operating theatres, the day case unit, the urgent care centre and the outpatients department.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because it represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Royal Cornwall Hospitals NHS Trust was considered to be a medium risk service.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

The inspection team inspected the following core services at this location:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 21 January 2014. During our visit we talked with patients and staff from all areas of the hospital, including the wards, theatre, outpatient departments and the urgent care centre. We observed how people were being cared for and talked with carers and/or family members, and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the location. An unannounced visit was carried out on 25 January 2014.

Good

Minor injuries unit

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

West Cornwall Hospital, Penzance, provides an urgent care centre service which is more comprehensive than a minor injury unit, but not as extensive as an Emergency Department. It is open 24 hours a day.

The service is categorised as a type 3 service; this means that it is a doctor-led service, and this is combined with an urgent care service provision with GP cover. Doctor cover is provided from 08.00 to 22.00 hours, with Emergency Nurse Practitioners providing overnight cover with support from Treliske Hospital and medical doctors on site.

Just over 18,000 patients attended the urgent care centre in 2012/13.

We talked with four patients, two relatives and twelve members of staff; they included all grades of nursing staff, healthcare assistants, domestic and portering staff, doctors and senior managers.

We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before our inspection, we reviewed information from, and about, the trust.

Summary of findings

The urgent care centre was a type 3 service in which patients received safe and effective care. There were sufficient numbers of staff, with appropriate qualifications, skills and experience to ensure that patient needs were met. The vast majority of patients were seen within four hours and additional resources were brought in to manage the higher demand for the service in the summer months. The centre was well-led. Staff were well supported and were confident in raising issues with senior managers.

Good

Minor injuries unit

Are accident and emergency services safe?

Good

Safety and performance

Patients were protected from avoidable harm. Staff were aware of policies and procedures that minimised risks, such as the infection control and incident reporting policy and procedures, and the actions to take if an incident occurred, with the priority on ensuring the immediate safety of the patient.

There was a risk register in place that covered both the emergency department at Treliske Hospital and West Cornwall Hospital. As a result of analysis of the risk, there were now standard operating policies in place for patients with minor injuries or less serious illnesses and clarity about the role of the nurse in charge. The risks from the department fed into the divisional risk register and the Divisional Management Board.

The centre did not accept patients with major injuries or requiring resuscitation; such patients were taken directly to Treliske Hospital. There was, however, a resuscitation area for any patients whose condition deteriorated whilst in the department, so they could be stabilised prior to transfer to Treliske Hospital. There were escalation procedures in place.

There were sufficient staff of an appropriate skill mix to deliver effective care and treatment. The team consisted of two substantive middle grade doctors, five GPs, 22 nurses (of various levels) and five receptionists. Locum doctors were also used, but tended to work regularly in the department, so knew the staff, systems and processes well. Staff felt the number and skill mix of staff was appropriate.

Learning and improvement

Staff learnt when things went wrong so that patient safety and standards could be improved. The investigation of complaints and incidents had highlighted issues with a lack of written documentation in records. Audits were being undertaken to review this, assess any improvements, and develop and implement actions to improve where necessary. Staff told us that information was cascaded to them through department meetings; this included learning from incidents and evidence of this was seen in notes of meetings and bulletins. Some staff felt that they learnt from incidents locally, but had less information cascaded to them which would enable learning from incidents occurring in other departments and hospitals within the trust.

Systems, processes and practices

There were reliable systems, processes and practices in place to keep people safe. These included the reporting of safety concerns and incidents in line with national guidance. Staff were aware of how to report incidents and could describe the process competently.

There were regular checks undertaken by pharmacy staff to ensure that medication was in date and there was sufficient stock. This ensured that patients could access the medication they required and that it would be within its expiry date.

Monitoring safety and responding to risk

Staff continually monitored the safety of patients and reacted appropriately to changes in level of risk. There were escalation processes in place and staff were aware of them. Appropriate checks were undertaken throughout the department to ensure that the equipment and environment were fit-for-purpose. Documents were seen that confirmed this.

There were risk-based audits undertaken, which included hand hygiene, peripheral line insertion and nursing care indicators. Results were positive.

Anticipation and planning

Problems were anticipated and planned for in advance, reducing any potential risk to patients. Due to the location of the hospital, there was an increase in attendance in the summer months, particularly in the school holidays; extra staffing was organised to cover these periods to ensure that patient care was not compromised or waiting times increased. Review of waiting times confirmed that patients did not wait longer at these times than at others.

Are accident and emergency services effective?

(for example, treatment is effective)

Good

Minor injuries unit

Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment was delivered in line with current legislation, standards and nationally recognised evidence-based guidance. The guidelines and care pathways were available on the intranet. We observed care, reviewed records and spoke with staff, and found that care was planned and delivered in line with the trust policies and procedures, and with patients' care plans. Documentation was appropriate.

The management team reviewed changes in national guidance and ensured that this was cascaded to staff. As well as information being available on the intranet, changes to policy documents were printed out and displayed, so that all staff were made aware of the changes. This ensured that up-to-date information was available to staff, to enable them to provide care based on the most recent guidance and best practice.

Performance, monitoring and improvement of outcomes

Performance was monitored through the performance assessment framework. The hospital performed well in relation to the time from arrival to treatment, and few patients left the department without being seen.

A range of audits were undertaken which included mandatory national audits, national audits conducted by the Royal College of Emergency Medicine, and local audits where issues had been raised by staff. All staff were involved in audits, with the service manager and senior nursing staff performing and reviewing regular audits of the departments processes.

Staff, equipment and facilities

Staff described having an effective appraisal in the last year. They spoke very positively about the process, stating that it had improved and was now much more constructive. They had access to continuing professional development. All staff spoken with had completed their mandatory training, and many had undertaken further training relevant to their role, and personal and professional development. Most staff stated that they were given time for additional training, but paid for the courses themselves.

Although staff were based in the urgent care centre, they did get opportunities to work in the accident and emergency department at Treliske Hospital, and this helped maintain their skills and experience. There was no formal clinical supervision for nursing staff.

Multidisciplinary working and support

There was good multidisciplinary working in the department, between services within the hospital and across the trust, as well as with external organisations. Staff felt well supported by the senior staff at the hospital and would readily approach them for advice or with concerns.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

Patients were made to feel safe and comfortable, and were treated with compassion and empathy while they received treatment and personal care. During the inspection, and through review on the NHS Choices website, we saw that patients spoke highly of the care and support they received. Comments included: “The Staff Nurse who attended to him was so kind and sympathetic and answered all of our questions. In fact everyone in the hospital that we encountered was helpful and kind.”

“The team were thorough, friendly, reassuring and very patient with me. I was extremely anxious and with the amazing nurses on duty coupled with a lovely doctor who took the time to talk me though the situation my mind was soon put at ease.”

“My teenage son hit his head and got a deep, bleeding gash in his head. We went to A&E. We were helped almost immediately by friendly, professional staff. Everything was clean. My son got stitches, and we were back home in under an hour. The stitches have been taken out last week, and there is virtually no scarring to be seen! I'm very impressed with the entire service.”

Good

Minor injuries unit

Involvement in care and decision-making

Patients (and where appropriate their relatives) were involved in their care, and were able to take part decision about their care in an informed manner. This was supported by patients' comments, observations and review of records.

Trust and communication

Staff developed trusting relationships with patients through good communication and respect of patients and their relatives. Comments from patients and our observations showed that staff spent time with patients to ensure that they understood their care and treatment plans.

Emotional support

Due to the location of the hospital, many patients who attended at the urgent care centre were holiday makers; the staff were aware of the particular challenges that this could cause and the emotional support that patients required at this time. Comments on the NHS choices website were very complimentary about the care and support; for example:

"The staff were all very pleasant and helpful to both myself, and also my wife and young children when they arrived approximately one hour later."

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patient needs were assessed, and care planned and delivered in line with this assessment. In the department, there was one nurse who was qualified as a registered mental nurse; however, staff described how they could also contact the local community mental health team when necessary, and had always had a prompt response. If children and young people attended the urgent care centre with minor injuries they would be treated and sent home; if the injury was major they would be transferred to Treliske Hospital. There was a direct referral process for referring children to the paediatric department at Treliske hospital when required, and staff stated that this worked well.

There was the facility within the department to care and treat for a patient on a short term basis, in order to prevent them from requiring admission. For example, if a patient came in unwell with a urinary tract infection requiring rehydration and antibiotics, they would be rehydrated and given antibiotics, monitored for four to six hours, and if their condition improved, they would be sent home with appropriate support; this would help to prevent an admission to hospital.

There were four trolley spaces which were used for patients presenting with major or minor illnesses. There was a paediatric space which was used flexibly and one resuscitation space.

The reception area was not welcoming, with a small window through which patients could speak to the receptionist, and this was situated in the corridor. The design of the waiting room meant that it was difficult to see all the patients who were waiting. There were plans in place to address these issues. The department was clean.

Vulnerable patients and capacity

Patient needs were met at each stage of their care, including when people were in vulnerable circumstances, or lacked the capacity to communicate their needs. Staff had received safeguarding training relating to both adults and children. The procedures were readily available, and one staff member explained how they had raised an issue of concern and how well the system had worked; and that they were pleased with the outcome and that the patient was safer as a result. There was good knowledge amongst staff of the Mental Capacity Act 2005 and the implications of this in order to protect patient rights.

Access to services

There was good access to the service; the number of patients who waited over four hours was very low at less than 0.5%. In July and August the number of attenders could increase by up to 600 patients a month compared to April and October. Additional resources were planned to meet this demand each year.

Leaving hospital

Patient's needs and wishes were taken into account, so they were ready to leave hospital at the right time, when they were well enough and with the right support in place. When patients left the department, they were sent away with relevant information, sufficient medication and dressings where appropriate.

Good

Minor injuries unit

Learning from experiences, concerns and complaints

Patients knew how to make a complaint if they were not satisfied with their care. Leaflets were seen around the department and hospital. The emergency department developed a tracker to monitor progress of complaints received. This helped to ensure that they were responded to in a timely manner, and allowed the team to follow up with clinicians and managers responsible for responding.

The department had used the findings from the National Accident and Emergency Experience Report of 2012 to improve care. There was a GP clinic in the department, in which the staff would see patients from around the area, as well as GP and emergency nurse practitioner referrals; this had helped to prevent admissions.

Are accident and emergency services well-led?

Good

Vision, strategy and risks

There was a vision and strategy to deliver high quality care to patients. The department had been a Type 1 emergency department changing to a Type 3, urgent care model in June 2012. It was reviewed after 12 months and continued to be reviewed to determine its effectiveness. It had strong support from both staff and the local community.

The reception and waiting area were not well suited to modern day health care; this had been acknowledged by the trust and plans were in place to improve the areas.

Overall, the department had a stable number of patients attending over the last two years, but it was noted that the age of attendees had increased, as well as their frailty and morbidity. The summer months saw an increase in the number of people attending the department, and arrangements were in place to manage this rise in demand.

Governance arrangements

The governance arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and problems detected, understood and addressed. The urgent care centre was part of the medicine, emergency department and West Cornwall Hospital Division. The division was led by a Divisional Director, Divisional Manager and Divisional Nurse. There was a monthly emergency department clinical governance meeting which looked at both clinical and operational issues. Messages and learning from this meeting were cascaded to all staff through department meetings, information on notice boards, and discussion at handovers.

Leadership and culture

The leadership and culture within the organisation reflected its vision and values, and promoted the delivery of high quality care across teams. Staff spoke highly of senior managers, particularly the matron and the divisional manager; they felt well supported in their roles and were comfortable in raising issues. Staff comments included: "... a very pleasant and amiable place to work ... patients receive excellent care and are very individually treated." One GP stated that: "this was the most efficient place (he) had ever worked, all investigations quick and efficient, radiology flexible and quick." Another member of staff stated: "… be happy for any member of my family to be treated in the hospital." Staff commented that communication and integration with the rest of the trust had improved over the last 18 months.

There was clearly respect between staff members throughout the hospital, and they valued each person's role and contribution.

Patient experiences, staff involvement and engagement

Patient's views and experiences were the key driver for how services were provided, and staff were involved and engaged. The urgent care centre was rated five stars out of five stars on the NHS Choices website, with few negative comments. All comments, both positive and negative, were shared with staff so that they could learn and improve care where necessary.

Staff commented that communication had improved over the last few months. There were weekly sisters meetings, and minutes were sent through, so you were able to keep up to date and involved if unable to attend. The messages from these meetings and minutes were then cascaded to staff. A daily bulletin was emailed if something urgent required cascading.

Good

Minor injuries unit

Learning, improvement, innovation and sustainability

Staff continuously strove to learn and improve; stating that they felt encouraged to do so. Learning and improvement was a key purpose of the various meetings held throughout the department. Staff were very aware of the population they served, and how this changed throughout the year, and the different skills that were required.

Good

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

There are two medical wards at the West Cornwall Hospital, providing a total of 54 in patient beds for the care of older people. We visited both of these wards.

Summary of findings

Patients received safe care. Staff were aware of how and when to report incidents; they got feedback on these and learnt lessons to improve patient care. Care was delivered in line with national standards and evidence-based practice; however, this was not always documented in a timely manner. There were sufficient staff with appropriate skills, knowledge and experience. A discharge liaison nurse position had been recently introduced and this was having a positive impact; however, there were patients whose discharge was being delayed due to a lack of appropriate support packages for care at home and limited care home beds. There was good awareness of the Mental Capacity Act 2005. Staff spoke very highly of the matron and the hospital was well-led.

Good

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety and performance

Patients were protected from avoidable harm, and patients told us that they felt safe. The Patient Safety Thermometer is a method that provides a quick and simple way of surveying any harm to patients and analysing the results so that staff can measure and monitor local improvement and harm free care over time. Through its use there was a drive to reduce avoidable harm that could occur in the wards, such as pressure ulcers, falls, infection and venous thromboembolism. The outcomes of these were monitored through the Performance Assessment Framework, the Trust Pressure Ulcer Group and the Falls Prevention Group. Feedback to staff was provided through the ward managers meetings, with actions developed, implemented and monitored as required.

Discussion of risks, incidents and trends took place at various levels, and information was fed back to staff in numerous ways; for example, through meetings, newsletters, summary reports and presentations. Where risks were identified on the risk register, there were a variety of reviews undertaken, depending on the severity of the risk; this could be local, or escalated to the Divisional Management Board, the Trusts Risk Committee and the Trust Risk Register, or the Board Assurance Framework.

There were sufficient staff of an appropriate skill mix to deliver safe care and treatment. This was supported by review of the rotas and during our inspection, staff did not raise significant concerns about staffing levels indeed some positive comments were made about the staffing levels being more appropriate than at other hospitals they had worked in. Additional staff could be accessed if a patient required one-to-one care in order to maintain their safety.

Patient records were not always kept up to date, which risked a patients care or condition deteriorating without the written evidence for staff to compare the patient's signs and symptoms. In reviewing one record, it was noted that the patient had been assessed as having a high risk of developing a pressure ulcer. The colour of the patients' sacrum, and the position they were assisted into, were documented at 05.30 hours; there was no further care or assessment documented when checked during the afternoon. This was raised with the staff; later when the records were check again, it was noted that they had since been completed; but the documented times were the times when the patient should have been checked; there was no documentation of the actual time that the records were made. This posed a risk to the patient, as it was not clear whether or not the care had been given, what time the care had been given and as the documentation was signed retrospectively, what time it was signed.

Numerous positive comments were received about the cleanliness of the hospital; for example: "I noticed how clean the ward is."

Learning and improvement

Staff learnt when things went wrong, so that patient safety and standards were improved. In June 2013, an increase in the number of falls was reported on both of the medical wards. An external review was undertaken of three falls, which identified the main themes and made recommendations. Actions included the improved identification of patients at risk (for instance, the use of yellow socks for patients at risk of falling), increased awareness and appropriate use of Trusts Safe and Supportive Policy, and proactive and timely assessment and re-assessment of patients at risk. The outcome for patients was that there was an overall reduction in the total number of falls, and of patients having multiple falls.

Systems, processes and practices

There were reliable systems, processes and practices in place to keep patients safe. Staff were aware of how and when to report incidents, and received feedback on any reports they made. They gave examples of a number of incidents they had reported, and changes that had been made as a result.

Monitoring safety and responding to risk

Staff continually monitored the safety of patients and reacted appropriately to changes in the level of risk.

In the corridors, on the entrance to the wards, there were displays on "How are we doing?" This included information on quality and safety, infection control, patient experience, productive wards (where improved ward processes and environments aim to allow nursing staff more time to spend on patient care), and cleaning. For areas which were not meeting targets, actions were detailed.

Good

Medical care (including older people's care)

Anticipation and planning

Problems were anticipated and planned for in advance, reducing any potential risk to patients. Staff assessed the dependency of the patients and any significant risks. If a patient required one-to-one care, for example, due to risks of falls, then additional staff were obtained to provide this care, and to reduce the risks relating to a lack of observation and care.

Are medical care services effective?

(for example, treatment is effective)

Good

Using evidence-based guidance

Care and treatment was delivered in line with current legislation, national standards and evidence-based practice. Pathways and clinical guidelines were available on the intranet and staff had access to these.

Performance, monitoring and improvement of outcomes

Performance was monitored through the performance assessment framework. There were notices in the corridors, to the entrance to the wards, entitled "How are we doing?" This included information on quality and safety, infection control, patient experience and cleaning. For areas which were not meeting targets, actions were detailed fo example ensuring all patients were screened for meticillin-resistant staphylococcus aureusis (MRSA prior to admission).

Patient needs were assessed, and care planned and delivered in line with this assessment. This was supported by review of records and patients comments:

"I need support with some aspect of my personal care and the staff have always delivered this is a personalised and caring way."

Staff, equipment and facilities

The majority of staff had received an appraisal in the last year and had undertaken mandatory training. They also accessed further training relevant to their role; for example, caring for people with dementia. Clinical supervision was underdeveloped with many staff saying they had limited access to this.

Appropriate checks were undertaken on equipment, and staff told us that there was enough equipment available to meet patient needs.

Multidisciplinary working and support

There was good multidisciplinary working within the medical wards, between other services in the hospital and across the trust, as well as with external organisations.

The Liverpool Care Pathway was a pathway of care designed to allow people with terminal illnesses to die with dignity however over the last few years there had been concerns nationally about it being used inappropriately. The Department of Health asked all acute hospital trusts to review patients on end of life care pathways in response to the national independent review 'More Care, Less Pathway: A Review of the Liverpool Care Pathway (2013)'. The hospital had recently phased out use of the Liverpool Care Pathway. There was a link nurse for palliative care and good access to the palliative care team, who provided advice and support with medication reviews, management of symptoms, and links with the hospice.

Are medical care services caring?

Good

Compassion, dignity and empathy

Patients were made to feel safe and comfortable, and were treated with compassion, dignity and empathy while they received treatment and personal care. The majority of people and their relatives described staff as kind with a caring attitude. We spoke with people at our listening events, reviewed comments sent to us, had discussions with patients on the ward areas, and observed care. The majority of comments were very positive; for example:

"Personal care is always delivered in a dignified way."

"The staff and doctors have always been good at respecting my privacy and dignity."

"The staff seem very kind, caring and attentive", "… treated with dignity and respect."

Involvement in care and decision-making

Patients (and where appropriate their relatives), were involved in their care, and were able to participate in decisions about their care in an informed manner. One

Good

Medical care (including older people's care)

patient stated that "they have been good at including me in the discussion (about my care) and have used plain English", and a relative commented that they felt included in the care planning process.

Trust and communication

Staff developed trusting relationships with patients through good communication, and respect of both patients and their relatives. Staff were open and honest, and also sensitive to individual patient needs and circumstances. Patients commented that they had sufficient information in order to make an informed choice about their care and consent: "I have always been asked for my consent before care is provided."

Emotional support

Patients received the support they needed to cope emotionally with their treatment and hospital stay. Accommodation in the wards was segregated, and with clear signs to state whether it was for the care of males or females. There was a chaplaincy service in the hospital, with access to leaders of all the main religious sectors as required.

The outside entrance to the mortuary was visible from the road and houses opposite. However, when vehicles visit the mortuary to transfer the deceased they block this view when on site, therefore making the process as private as possible.

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patient nutritional needs were met through the provisionof apprioriate food and fluids. For example one patient stated:

"The food here is incredible, great choice; good food, plenty to eat, drinks and snacks are available and personalised."

Although the majority of comments were positive about the responsiveness of staff, there were some negatives, such as "... staff too busy to give really personalised care, too busy for the little things, e.g. supporting Dad to know how to turn on his light".

Much consideration had been given to the environment on the medical wards as a suitable place for caring for patients with dementia. The housekeeper had been influential in offering small meals, often to suit patient's individual needs. Each Thursday afternoon on Medical Ward 2 the day room was converted into a memory café, where the patients could have tea and cake in china cups and saucers, and there were activities and/or celebrations at appropriate times of the year. It was spoken very highly of by both patients and relatives. Indeed, a patient whose husband was visiting her and had dementia, went to the café during the visiting session, and the patient commented that it was the first time she had seen her husband laugh for years.

Vulnerable patients and capacity

Patient needs were met at each stage of their care, including when people were in vulnerable circumstances, or lacked the capacity to communicate their needs. Staff spoken with, had undertaken appropriate safeguarding training and records confirmed this. They were aware of the Mental Capacity Act 2005, and the implications of this in order to protect patient's rights. Through a review of the records, we saw that staff had assessed patients' mental capacity for making decisions; this included the recording of who was involved in the decisions, and how the decisions had been made. Staff were aware that patients had to be reassessed for each decision, and that they may have the capacity for some, but not all decisions.

Access to services

There was good access to services within the hospital, although the bed occupancy regularly ran at about 92%. However, there was limited access to suitable facilities in the community for patients to be sent home in a timely manner, with appropriate care packages in place.

Leaving hospital

Patient needs and wishes were taken into account, so they were ready to leave hospital at the right time, when they were well enough, and with the right support in place; however, there were delayed discharges due to the availability of appropriate support packages for care at home or care home beds. One of the nursing posts now focused on arranging discharges, and staff and patients found this very effective. The discharge liaison nurse explained that the majority of patients had complex needs, and described how the liaison role enabled closer multiagency working and safer discharges. There was also

Good

Medical care (including older people's care)

care co-ordinator/social worker input into the daily ward rounds. Patients also gave examples of their involvement in the discharge plans: "I have been involved in care planning and discharge plan. I am very happy with this."

"I have been given a copy of my discharge plan."

Learning from experiences, concerns and complaints

Patients knew how to make a complaint if they were not satisfied with their care. Leaflets were seen around the wards and hospital. Themes and trends from complaints were viewed at the specialty meetings, these are meetings of key staff with in that specialty, for example, respiratory, eldercare or gastroenterology. Areas of concern were escalated to the Divisional Medical Board. Learning from complaints was fed back to staff through ward meetings and the ward newsletters and notes of meetings and review of a newsletter confirmed this.

Are medical care services well-led?

Good

Vision, strategy and risks

There was a vision and strategy to deliver high quality care to patients. Staff commented that things were getting better. They spoke of more engagement with the executive team, and mentioned the last visit by a non-executive director; they stated that they had received written comments back after this visit, and issues raised as a result of the visit were being addressed and monitored.

Governance arrangements

The governance arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and problems detected, understood and addressed. Governance was an integral part of the Divisional Management Board which met monthly. The attendees included the senior management team, the clinical leads from each the specialities, the speciality clinical matrons, the speciality service and performance managers, and the divisional governance leads. It was important to the team, and the leads of both nursing and medical governance were seen frequently by staff, so that governance was an integral part of care, rather than something only discussed at meetings

Leadership and culture

The leadership and culture within the organisation reflected its vision and values, and promoted the delivery of high quality care across teams. Staff spoke highly of the leadership in the hospital, saying that both the matron and the divisional manager were approachable and visited the wards most days. One member of staff stated that they had the freedom to try new things on the ward and that their suggestions were respected.

Patient experiences, staff involvement and engagement

Patient views and experiences were the key driver for how services were provided and how staff were involved and engaged. Information about the ward or department was displayed in the corridors. This was visible to staff, patients and visitors, and helped to provide a culture of openness. The displays were titled "How are we doing?" and "Patient experience". This included information on the Friends and Family test, feedback from patients, and quality and safety information; for example, results from audits of hand hygiene, safe storage of medicines and number of falls and pressure ulcers. One patient commented, "I would say that this is a well managed and excellent local hospital".

Learning, improvement, innovation and sustainability

The end of life care team responded quickly to referrals throughout the hospital, and this ensured patients received an effective end of life care service. The trust had developed a strategy for end of life care that included links with community hospitals, community services such as district nurses, and the local hospices. This ensured patients had support wherever they were Quality markers were set at ward level, and were monitored through the performance Assessment Framework, the Trust Pressure Ulcer Group and the Falls Prevention Group. Key areas that are doing well, or not so well, are highlighted at the Ward Manager meetings and actions.

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The surgical unit at West Cornwall Hospital consists of two operating theatres, a recovery ward and a day case area. Operations take place Monday to Friday. Any patients who need to stay in overnight are transferred to one of the medical wards. Surgery is only undertaken on adults. We visited the operating epartemnt and day case area.

Summary of findings

Patients received safe and effective care. Staff were aware of how and when to report incidents; they got feedback on these and learnt lessons to improve patient care. Care was delivered in line with national standards and evidence-based practice. There was good awareness of the Mental Capacity Act 2005. Staff were caring and compassionate, although as there were no curtains at the windows, the patient's privacy and dignity could be compromised.

Good

Surgery

Are surgery services safe?

Good

Safety and performance

Patients were protected from avoidable harm. There had been three never events (these are largely preventable patient safety incidents that should not occur), in surgery across the trust in the last year. None of these had occurred in the theatres at this hospital.

The theatres, recovery ward and case unit were clean. Staff were using personal protective equipment, such as theatre scrubs, aprons, gloves, goggles, etc. appropriately. Hand gel was available in all areas with signs prompting people to use it.

There were sufficient staff in the theatres, recovery and day unit to care for people effectively. These numbers of staff and skill mix reflected the needs of patients and the fast pace of day case surgery.

Learning and improvement

Staff learnt when things went wrong, and as a result, they improved safety and standards for patients. Staff had learnt lessons from the never events that had occurred within the trust, and had implemented actions to minimise the risk of this occurring in this hospital. Compliance with the World Health Organization (WHO) surgical checklists was good at 100% compliance. Staff also spoke of wider learning from incidents, and that information was cascaded through to staff via the department manager.

There had been incidents across the trust in which the packaging of theatre sets had been found be damaged; this meant that the sets could not be considered sterile. The trust had investigated this to ascertain the cause; however, there was no one, clear explanation; therefore, they had taken a number of actions to reduce the risk of this continuing to happen. These actions included reviewing the storage and handling of the packages, and changing the outer wrapper to a thicker, most robust material. The incidents had significantly reduced with these actions.

Systems, processes and practices

There were reliable systems, processes and practices in place to keep patients safe. These included the reporting, investigating and monitoring of safety concerns and incidents in line with national guidance. Staff told us that they knew how to report incidents and could describe the process competently. Review of incidents supported this.

Monitoring safety and responding to risk

Staff continually monitored the safety of patients and reacted appropriately to changes in the levels of risk. A programme of risk-based audits was undertaken. These included an audit of compliance with the World Health Organization (WHO) checklists, and infection control audits; for example, of hand hygiene, cannula insertion and catheterisation. These audits lasted a week and were carried out monthly. Findings were positive.

Anticipation and planning

Problems were anticipated and planned for in advance, reducing potential risk to patients. Patients attended a pre-operative assessment at St Michael's Hospital, which is another location run by this trust. The assessment ensured that West Cornwall Hospital was a suitable place for patients to have their surgery. Any issues that were identified were discussed with the multidisciplinary team, and if concerns remained, patients would be transferred to Treliske Hospital for their surgery.

Are surgery services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance

Care and treatment was delivered in line with current legislation, standards and nationally recognised evidence-based guidance. We observed care in both theatres and the recovery area, reviewed records and spoke with staff. Care observed was in line with the trust policies and procedures, and patients' care plans. Medical and nursing documentation was appropriate, and staff were knowledgeable about the patients in their care and the care required.

Performance, monitoring and improvement of outcomes

Patients undergoing elective inpatient surgery for four common elective procedures (hip and knee replacement, varicose vein surgery and groin hernia surgery) funded by the English NHS, were asked to complete questionnaires

before and after their operations, to assess improvement in health as perceived by the patients themselves. These results are known as patient reported outcome measures (PROMS) and they showed that there were good outcomes for patients and no evidence of risk. .

Overall, mortality rates for surgical patients at trust-wide level were within normal range, so did not demonstrate evidence of risk. The surgical division monitored mortality rates and took actions where required.

A number of local audits were undertaken, such as hand hygiene, catheterisation, and intravenous peripheral line insertion; surgical services performed well in all these areas.

Staff, equipment and facilities

Appropriate equipment was available for patients when required.

The clinical areas were clean and uncluttered. There was hand gel available in all areas and staff were seen using it appropriately.

Multidisciplinary working and support

There was good multidisciplinary working within surgical services, between other services in the hospital and across the trust, as well as with external organisations. Many staff commented on the "... good team work here ...", "... work well as a team". Our observations supported good multidisciplinary working

Are surgery services caring?

Good

Compassion, dignity and empathy

Patients were made to feel safe and comfortable, and were treated with compassion, dignity and empathy while they received treatment and personal care. Patients spoke highly of the care they had received, and our observations supported this. Privacy and dignity was maintained in the day unit and theatres; however, in the recovery area this risked being compromised, due to the lack of curtains or screens at one window into recovery, which meant that patients could be seen without any privacy.

There was a risk to patient confidentiality being compromised in the theatre reception area. On our arrival there the reception was unmanned, with no call bell, and the lists detailing the patients and their operations for the day were left out in a position that was easy for anyone to read whilst waiting.

Involvement in care and decision-making

Patients (and where appropriate their relatives) were involved in their care, and were able to participate in decisions about their care in an informed manner. We observed that patients were involved in their care and decision-making; for example, from whether they walked to theatre, to consenting to surgery.

Trust and communication

Staff developed trusting relationships with patients, through good communication and respect of both patients and their relatives. Patients were asked for their consent before treatment, and could base their decision on appropriate information. We observed consent being rechecked prior to surgery. Staff were aware of and understood the Mental Capacity Act 2005 and of the action they should take if they had concerns over a patient's ability to consent.

Emotional support

Patients received the support they needed to cope emotionally with their treatment and hospital stay. Emotional support for patients started in the patient's preparation at the pre-operative assessment clinic, and the ward and theatre staff built on the assessment undertaken there. A chaplaincy service was available to people of all denominations.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patient's needs were assessed, and care planned and delivered in line with this assessment. This was supported by the review of records. This assessment started in the preoperative assessment clinic and was continued during the patients hospital stay. These assessments were undertaen in a timely manner.

Good

Surgery

Vulnerable patients and capacity

Patient's needs were met at each stage of their care, including when people were in vulnerable circumstances, or lacked the capacity to communicate their needs. Staff had undertaken appropriate safeguarding training and records confirmed this. They were aware of the Mental Capacity Act 2005 and the implications of this in order to protect patient's rights. Through a review of the records we saw that staff had assessed patients' mental capacity for making decisions; this included the recording of who was involved in the decisions and how the decision had been made. Staff were aware that patients had to be reassessed for each decision and that they may have the capacity for some, but not all decisions.

Access to services

There was good access to services. A 'text' reminder service for elective surgery was introduced in October 2013, which has seen a reduction in patient cancellations on the day attributable to patient-related reasons. Patients spoke well of their ability to access the services; indeed, one commented that their expectations were exceeded as they came in for their operation earlier then they had anticipated.

The scheduling of patients for surgery was done by administrative staff, with the consultants not always knowing in advance who was on the lists. This could cause problems in ensuring that the mix of procedures on the list was appropriate for the time and equipment available. There was no "lock down" of the list, so the list could be changed at any time.

Leaving hospital

Patients needs and wishes were taken into account, so they were ready to leave hospital at the right time, when they were well enough and with the right support in place. Plans were developed with patients and their relatives in preparation for discharge home. Patients and staff explained that this planning started in the pre-operative assessment clinic, and was further supported during the patients stay in hospital. Records confirmed this. Patients were discharged with information (both verbal and written), and medication and dressings where appropriate.

Learning from experiences, concerns and complaints

Patients knew how to make a complaint if they were not satisfied with their care. Leaflets were seen around the wards and hospital. There were very few complaints about surgical services at this hospital; any that were received were reviewed along with compliments and concerns raised on the NHS Choices website

Are surgery services well-led?

Good

Vision, strategy and risks

There was a vision and strategy to deliver high quality care to patients and it was evident through discussion with staff that this was their key aim.. There were clear criteria to ensure that patients were admitted to West Cornwall Hospital appropriately, based on the level of risk and medical cover available. Staff did comment that the lists were not always full, so some capacity was wasted.

Governance arrangements

The governance arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and problems detected, understood and addressed. Overall leadership and governance for the wards and theatre was provided through the division of surgery. The divisional manager and matrons were key in cascading quality and performance information to staff. Staff confirmed they received information through a variety of media.

Leadership and culture

The leadership and culture within the organisation reflected its vision and values, and promoted the delivery of high quality care across teams. There were very good working relationships between all staff across West Cornwall Hospital. Staff were proud to work at the hospital and we heard comments such as "staff have pride in their work", "we work well as a team", "no bank staff used, we rally round", and "we're really lucky". Staff supported each other.

Patient experiences, staff involvement and engagement

Patient views and experiences were the key driver for how services were provided, and how staff were involved and engaged. Information about the ward or department was displayed in the corridors. This was visible to staff, patients and visitors, and helped to provide a culture of openness. The displays were titled "How are we doing?" and "Patient

experience"; this included information on the Friends and Family test, feedback from patients, and quality and safety information; for example, results from audits of hand hygiene, safe storage of medicines, and the number of falls and pressure ulcers.

Staff commented that communication and information across the trust had improved in the last couple of years.

Learning, improvement, innovation and sustainability

Staff continuously strove to learn and improve; stating they felt encouraged to do so. The risk management process, the use of incident reporting and analysis, and learning from incidents, complaints and patient comments, promoted a learning environment.

Good

Outpatients

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The outpatients department offers clinics for breast care, ear, nose and throat services, geriatric medicine services, gastroenterology and hepatology services, general surgery, oral and maxillo-facial services, orthopaedic services, vascular surgery services and some children's and young peoples services.

Summary of findings

Patients received safe and effective care delivered by appropriate numbers of staff with relevant qualifications for their roles. The department was well-led. The environment was not well suited to the delivery of modern day healthcare; however, it had been recently refurbished, and significant effort made to make it user-friendly, with colour coded areas to help patients find their way around.

Good

Outpatients

Are outpatients services safe?

Good

Safety and performance

Patients were protected for avoidable harm. There were no major risks reported on the trust risk register relating to the outpatients service at West Cornwall Hospital.

The outpatients department was located in a building which was the former nurses home, with narrow corridors and small rooms, making it not well suited to modern day healthcare. Staff were very aware of the risk that the environment could pose, and were very proactive in managing these, such as discussing issues with the local fire department and trust health and safety staff, to reduce risk to anyone on the premises. This was documented in the local risk register.

There were sufficient staff of an appropriate skill mix to deliver effective care and treatment. Our observations, staff comments and review of duty rotas confirmed this. Staff spoke of how the manager would often cover shifts when there was absence to ensure the smooth running the department, and that safe and effective care was maintained for patients. During our inspection staff did not raise significant concerns about staffing levels.

Learning and improvement

Staff learnt when things went wrong, so that patient safety and standards were improved, an example of this was following an issue with a backlog of patients for follow up in on speciality there was now weekly monitoring with a focus on improvement trajectories. There had been few incidents reported, which is not uncommon in this type of service, however when incidents had been reported, there was feedback to the staff involved and lessons learnt where appropriate. Staff spoken with had undertaken safeguarding training for both adults and children; they were aware who the safeguarding leads were and of the actions to take if they had concerns.

Systems, processes and practices

There were reliable systems, processes and practices in place to keep patients safe. These included the reporting of safety concerns and incidents in line with national guidance. Staff were aware of how to report incidents and they received feedback on these.

Risks identified in outpatients were managed either through the outpatient team, or through the divisional governance arrangements, reporting on to the trust-wide risk committee, as appropriate.

Monitoring safety and responding to risk

Staff continually monitored the safety of patients and reacted appropriately to changes in the level of risk.

Appropriate checks were undertaken throughout the department to ensure that the environment and equipment were fit-for-purpose. Documents were seen demonstrating that necessary checks were being completed, such as daily fridge temperatures, and emergency trolley, weekly room and equipment checks.

Anticipation and planning

Problems were anticipated and planned for in advance, reducing any potential risk to patients. Regular clinics were booked in advance and consultant availability was reviewed to prevent cancellations. Extra clinics were slotted in if there was extra availability or cancellations.

Are outpatients services effective?
(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Care and treatment was delivered in line with current legislation, standards and nationally recognised evidence-based guidance. We observed care, reviewed records and spoke with staff, and found that care was delivered in line with the trusts policies and procedures.

Staff, equipment and facilities

Permanent staff told us they had received an appraisal in the last year; however, bank staff did not get appraisals and the middle manager had had an appraisal, but not in the last 12 months. A good appraisal system enables objectives to be set for staff and their performance monitored against these providing constructive criticism on areas for improvement and praising good practice with the aim of improving patient care. There was very good support within teams and across multidisciplinary teams; however, clinical supervision particularly for nursing staff was underdeveloped.

Good

Outpatients

All staff spoken with had attended the relevant mandatory training for their role, and records confirmed this. Staff also explained that they were actively encouraged by their manager to undertake additional training to support them in their role and develop their interests.

Multidisciplinary working and support

There was good multidisciplinary working within the outpatients department, between other services in the hospital and across the trust, as well as with external organisations. Both patients and staff from a variety of disciplines spoke of good multidisciplinary working and our observations supported this. One member of bank staff stated: "... very good teamwork, we move around all clinics and everyone is very helpful and supportive".

Are outpatients services caring?

Good

Compassion, dignity and empathy

Patients were made to feel safe and comfortable and were treated with compassion, dignity and empathy while they received treatment and care. During the inspection we observed that consultations took place in private rooms and staff did not discuss patients in public places such as corridors. Staff spoke of how patients were the priority for the team and all their work ensured this was reflected.

Involvement in care and decision-making

Patients (and where appropriate their relatives) were involved in their care, and were able to participate in decisions about their care in an informed manner. Patients told us they received sufficient information to be involved in their care and decision-making, and were able to give informed consent for treatments. There was sufficient time in their appointment slot to ask questions and they did not feel rushed.

Trust and communication

Staff developed trusting relationships with patients through good communication and respect of both patients and their relatives. Patients commented that all staff communicated with them appropriately from the consultant to the nursing staff and the volunteers.

Emotional support

Patients received the support they needed to cope emotionally with their treatment and care. Staff were aware that some patients attending the department may receive information about their health that could cause them distress. They reviewed patient's records in preparation for the clinic and, where possible, ensured that appropriate staff were available to support the patient and their relatives.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Patient's needs were assessed at each appointment, and care planned and delivered to meet these needs. All staff had received training care for people with learning disabilities and dementia. Staff aimed to find an appropriate place for any patients with special needs, for instance, in a separate room, and prioritised them to avoid any distress due to waiting.

The outpatients department was in an old part of the hospital having previously being the nurse's home; the corridors were very narrow and the rooms quite small and not well suited to modern health care. However, staff were making it as accessible as possible. It had its own entrance and was spilt into different waiting rooms, which were colour coded, making it easier for patients to find their way around.

The department had a calm atmosphere and tea and coffee was available for patients whilst they waited. There was good support to the department from volunteers from the friends of the hospital.

Vulnerable patients and capacity

Patient needs were met at each stage of their care, including when people were in vulnerable circumstances or lacked the capacity to communicate their needs. All staff had undertaken mandatory safeguarding training and were aware of the action to take if they had concerns. Staff were aware of the need to assess children for their ability to consent; they were also aware of the Mental Capacity Act 2005 and the need to protect patients' rights.

Good

Outpatients

Access to services

There was good access to services. The Trusts Access Policy had recently been reviewed, which aimed to ensure that patients waiting for an outpatient appointment and/or diagnostics, were managed in line with national waiting list guidance and patient choice.

Performance was monitored through the performance assessment framework in each of the divisions in which issues such as cancelled clinics and 'did not attend rates' were reviewed. Times from referral to treatment were monitored through weekly meetings, which were chaired by a member of the executive team and were attended by the divisional managers and heads of service. With the exception of ophthalmology referral to treatment times were within normal limits.

A number of audits had been undertaken over the last two years, including: a Payment by Results data assurance framework follow up audit 2011/12 (original Audit 2009/10); Internal clinical coding reports; and the internal audit team had also undertaken audits through the trust's own audit programme. Other reviews included the Outpatient Booking Service Review, June 2012 and Waiting List Management August 2013. Actions had been put in place as a result of these, and both these and other issues were communicated through the regular meetings of the administrative and clerical staff.

If clinics were running late, staff kept the patients informed. A patient survey from 2012 showed that 84% of patients stated that they were kept informed of any delays to appointment times. If patients were relying on ambulance transport, or had come from the Isles of Scilly and were dependent on flight times, staff ensured that they were prioritised to prevent any unnecessary delays and the associated anxiety that this could cause.

The number of patients who did not attend their outpatient's appointment was monitored; text reminders had been introduced and further developments, such as phoning patients, were being introduced.

Leaving hospital

Patient's needs and wishes were taken into account, so that they left the department with appropriate information, and any necessary medication.

Learning from experiences, concerns and complaints

Patients knew how to make a complaint if they were not satisfied with their care. Leaflets were seen around the department and hospital. There were few formal complaints made in the outpatients department, but there were issues of concern raised with the Patient Advice and Liaison Service (PALS). These included patients not having received an appointment letter, cancelled appointments and customer service. Action had been taken in relation to all of these; for example, a text reminder service had been set up and there had been a recent publicity campaign to promote this. In a patients survey from 2012 only two thirds of patients completing the survey knew who to raise concerns or complaints with, within the hospital.

Are outpatients services well-led?

Good

Vision, strategy and risks

There was a vision and strategy to deliver high quality care to patients. There was a monthly outpatient improvement group chaired by the chief operating officer, with clinical engagement to explore pathway redesign, future direction for outpatients, and where efficiencies and improvements could be made to current practices. The outpatients department was in an old area of the hospital and was not well suited to modern day healthcare. There were plans in place to relocate it in 2016. The trust was aiming to make the most of the current facilities, and the department had recently been refurbished with colour coded areas to help patients find their way around.

Governance arrangements

The governance arrangements ensured that responsibilities were clear, quality and performance were regularly considered, and problems detected, understood and addressed. Issues raised in the outpatients department were discussed in the department where possible. If they needed to be escalated they went through the divisional governance arrangements and, if necessary, were escalated further to executive level as required.

Leadership and culture

The leadership and culture within the organisation reflected its vision and values, and promoted the delivery

Good

Outpatients

of high quality care across teams. Staff spoke very highly of the department manager, who they found very supportive and who always ensured that the patient was at the heart of the department.

Patient experiences, staff involvement and engagement

Patient views and experiences were the key driver for how services were provided and how staff were involved and engaged. There were some complaints relating to appointment delays, but staff aimed to keep patients informed of any delays. The National Outpatient Survey in 2011 was generally positive, with a good response rate of 63%.

Learning, improvement, innovation and sustainability

Staff continuously strove to learn and improve; stating they felt encouraged to do so in order to promote improvements to patient care.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 20: Records **How the regulation was not being met:** The provider had not ensured that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each patient which should include appropriate information and documents in relation to the care and treatment provided to each patient. Within the medical wards patient records were not always kept up to date, which risked a patients care or condition deteriorating without the written evidence for staff to compare the patient's signs and symptoms. This posed a risk to the patient as it was not clear if the care had been given and whether or not, the documentation had been signed retrospectively as the time of signing was not recorded.

Regulated activity	Regulation
Diagnostic and screening procedures	Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 20: Records **How the regulation was not being met:** The provider had not ensured that patients were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of

This section is primarily information for the provider

Compliance actions

an accurate record in respect of each patient which should include appropriate information and documents in relation to the care and treatment provided to each patient.

Within the medical wards patient records were not always kept up to date, which risked a patients care or condition deteriorating without the written evidence for staff to compare the patient's signs and symptoms. This posed a risk to the patient as it was not clear if the care had been given and whether or not, the documentation had been signed retrospectively as the time of signing was not recorded.