Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Royal Cornwall Hospital

Inspected but not rated

Royal Cornwall Hospitals NHS Trust (RCHT) is the main provider of acute hospital and specialist services for most of the population of Cornwall and the Isles of Scilly, 587,000 people. The population can more than double during busy holiday periods. The trust delivers care from three main sites – Royal Cornwall Hospital in Truro, St Michael's Hospital in Hayle and West Cornwall Hospital in Penzance. The service employed 5,683 staff as at September 2021.

We carried out an unannounced focused inspection of Royal Cornwall Hospital urgent and emergency care services (also known as accident and emergency - A&E) and medical care services (including older people's care) between 8 and 10 March 2022. We had an additional focus on the urgent and emergency care pathway across Cornwall and carried out a number of inspections of services over a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

As this was a focused inspection at Royal Cornwall Hospital emergency department (ED), we only inspected parts of four key questions: safe, responsive, caring and well led and did not inspect effective. In medicine we inspected all five key questions.

Our inspection had a short announcement of around 30 minutes to enable staff to arrange to meet with us and for us to carry out our work safely and effectively.

For this inspection we considered information and data on emergency department performance and medical care.

We looked at the experience of patients using urgent and emergency care and medical care services in Royal Cornwall Hospital. This included the emergency department but also areas where patients in that pathway were cared for while waiting for treatment or admission. We also visited wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department was managed by the hospital. During the inspection the trust had an outbreak of COVID-19 which resulted in several medical wards and some bays on other medical wards were closed. We were not able to visit these wards and bays during this inspection.

A summary of CQC findings on urgent and emergency care services in Cornwall.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Cornwall below:

Cornwall

The health and care system in this area is under extreme pressure and struggling to meet people's needs in a safe and timely way. We have identified a high level of risk to people's health when trying to access urgent and emergency care in

Our findings

Cornwall. Provision of urgent and emergency care in Cornwall is supported by services, stakeholders, commissioners and the local authority and stakeholders were aware of the challenges across Cornwall; however, performance has remained poor, and people are unable to access the right urgent and emergency care, in the right place, at the right time.

We found significant delays to people's treatment across primary care, urgent care, 999 and acute services which put people at risk of harm. Staff reported feeling very tired due to the on-going pressures which were exacerbated by high levels of staff sickness and staff leaving health and social care. All sectors were struggling to recruit to vacant posts. We found a particularly high level of staff absence across social care resulting in long delays for people waiting to leave hospital to receive social care either in their own home or in a care setting.

GP practices reported concerns about the availability of urgent and emergency responses, often resulting in significant delays in 999 responses for patients who were seriously unwell and GPs needing to provide emergency treatment or extended care whilst waiting for an ambulance. GPs also reported a lack of capacity in mental health services which resulted in people's needs not being appropriately met, as well as a shortage of District Nurses in Cornwall.

A lack of dental and mental health support also presented significant challenges to the NHS111 service who were actively managing their own performance but needed additional resources available in the community to avoid signposting people to acute services. The NHS111 service in Cornwall worked to deliver timely access to people in this area, whilst performance was below national targets it was better than other areas in England.

Urgent care services were available in the community, including urgent treatment centres and minor illness and injury units and these services were promoted across Cornwall. These services adapted where possible to the change in pressures across Cornwall. When services experienced staffing issues, some units would be closed. When a decision was made to close a minor injury unit (MIU) the trust diverted patients to the nearest alternative MIU and updated the systems directory of services to reflect this. However, this carried a potential risk of increased waiting times in other minor injury units and of more people attending emergency departments to access treatment. This had been highlighted on the trust's risk register.

Due to the increased pressures in health and social care across Cornwall, we found some patients presented or were taken to urgent care services who were acutely unwell or who required dental or mental health care which wasn't available elsewhere. Staff working in these services treated those patients to the best of their ability; however, patients were not always receiving the right care in the right place.

Delays in ambulance response times in Cornwall are extremely concerning and pose a high level of risk to patient safety. Ambulance handover delays at hospitals in the region were some of the highest recorded in England. This resulted in people being treated in the ambulances outside of the hospital, it also meant a significant reduction in the number of ambulances available to respond to 999 calls. These delays impacted on the safe care and treatment people received and posed a high risk to people awaiting a 999 response. At the time of our inspection, the ambulance service in Cornwall escalated safety concerns to NHS England and NHS Improvement.

Staff working in the ambulance service reported significant difficulties in accessing alternative pathways to Emergency Departments (ED). When trying to access acute assessment units, staff reported being bounced back and forth between services and resorting to ED as they were unable to get their patient accepted. Many other alternative pathways were

Our findings

only available in specific geographical areas and within specific times, making it challenging for front line ambulance crews to know what services they could access and when. In addition, ambulance staff were not always empowered to make referrals to alternative services. The complexity of these pathways often resulted in patients being conveyed to the ED.

Hospital wards were frequently being adapted to meet changes in demand and due to the impact of COVID-19. There was a significant number of people who were medically fit for discharge but remaining in the hospital impacting on the care delivered to other patients. The hospital had created additional space to accommodate patients who were fit for discharge but were awaiting care packages in the community; however, staff were stretched to care for these patients.

Delays in discharge from acute medical care impacted on patient flow across urgent and emergency care pathways. This also resulted in delays in handovers from ambulance crews, prolonged waits and overcrowding in the Emergency Department due to the lack of bed capacity. We found that care and treatment was not always provided in the ED in a timely way due to overcrowding, staffing issues and additional pressure on those working in the department. These delays in care and treatment put people at risk of harm.

In response to COVID-19, community assessment and treatment units (CATUs) had been established in Cornwall. These wards were designed to support patient flow, avoid admission into acute hospitals and provide timely diagnostic tests and assessments. However, these wards were full and unable to admit patients and experienced delayed discharges due to a lack of onward care provision in the community.

Community nursing teams had been recently established to support admissions avoidance and improved discharge. This work spanned across health and social care; however, at the time of our inspections it was in its infancy so we could not assess the impact.

The reasons for delayed discharge are complex and we found that discharge processes should be improved to prevent delays where possible. However, we recognise that patient flow across the Urgent and Emergency Care pathway in Cornwall is significantly impacted on by a shortage of staffed capacity in social care services. Staff shortages in social care across Cornwall, especially for nursing staff, are some of the highest seen in England. This staffing crisis is resulting in a shortage of domiciliary care packages and care home capacity meaning many people cannot be safely discharged from hospital. A care hotel has been established in Cornwall providing very short-term care for people with very low levels of care needs; this is working well for those who meet the criteria for staying in the hotel, however this is a relatively small number of people.

Without significant improvement in patient flow and better collaborative working between health and social care, it is unlikely that patient safety and performance across urgent and emergency care will improve. Whilst we have seen some pilots and community services adapted to meet changes in demand, additional focus on health promotion and preventative healthcare is needed to support people to manage their own health needs. People trying to access urgent and emergency care in Cornwall experience significant challenges and delays and do not always receive timely, appropriate care to meet their needs and people are at increased risk of harm

Summary of CQC findings on services at Royal Cornwall Hospital.

Urgent and emergency care

- The service controlled infection risk well;

Our findings

- Staff assessed patients and completed risk assessments for each patient as quickly as practically possible;
- Treatment of stroke within the emergency department was compared nationally with other trusts;
- Staff treated patients with compassion and kindness and took account of their individual needs;
- The trust had successfully recruited to four consultant grade posts and will be fully established for consultant grade staff within the emergency department;
- Leaders and teams used systems to manage performance effectively.

Medical care

- The service controlled infection risk well. Staff assessed risks to patients, acted on them. They managed medicines well.
- Staff worked well together for the benefit of patients. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Leaders ran services well using reliable information systems. Risk to the service provision were identified and actions devised to help minimise these.

However:

Urgent and emergency care

- The Trust faced challenges with access and flow which meant they could not always ensure patients accessed the emergency department when needed, or ensure they received timely treatment;
- Patients were not receiving timely treatment; for example, some patients were not assessed or triaged within 15 minutes of arrival as per the national standard and some patients identified as being at risk of developing sepsis were not receiving antibiotics within one hour;
- Patients were waiting for long periods in the emergency department.
- Patients, experiencing chest pains, did not always receive an electrocardiogram (ECG) as soon as possible as per recommendations of the National Institute for Health and Care Excellence (NICE).
- Staff were not receiving mandatory training or appraisals;
- The environment that was designed to look after patients with minor injuries was being used for patients of greater acuity and was not suitable for this purpose. It was not always staffed to manage the level of the patient's acuity;
- The mental health assessment room was being used to treat clinical patients and therefore the trust did not have a dedicated available room that was equipped to provide a safe and private environment for psychiatric assessments;
- There was a high turnover of ED nursing staff, leaving the department struggling for experienced nurses.

Medical care

Our findings

- The service did not always have enough staff to care for patients and keep them safe. Some staff were moved to wards they were not familiar with to help maintain safer staffing levels. When capacity within services was pressured, they used areas that were not always suitable for patients and lacked some facilities.
- Outcomes for stroke patients did not always meet national standards. Information about some patients care needs was not shared with care or nursing homes on discharge which places patients at risk of unsafe care.
- People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Patients were being moved sometimes multiple times, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment. Delays for patients waiting for cardiology investigations impacted on the demand for beds.
- Changes in the executive leadership team of the trust had impacted negatively on the staff. Some staff felt the new senior leadership for the trust did not visit the medical areas impacted by demand sooner. Morale was low for some staff in the service due to the immense and unrelenting pressures which had been ongoing for a number of years.

Urgent and emergency services

Inspected but not rated

Royal Cornwall Hospitals NHS Trust (RCHT) provides emergency department services for adults and children. The ED accepts patients transported by ambulance or those who arrive independently. It is open 24 hours a day, seven days a week. The trust is the only acute hospital serving the county of Cornwall and the Scilly Isles.

Total A&E attendances at RCHT between September 2020 and August 2021 were 166,760 and of these, 33,221 were children. The previous years attendance was 173,658. According to the number of attendances, RCHT is classified as a large emergency department as defined by the Royal College of Emergency Medicine.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff understood the different forms of abuse and what action to take to promote patient safety. They knew how to report safeguarding concerns and understood how to flag patients as safeguarding concerns on the IT systems. The provider had a safeguarding team which staff could approach for additional advice.

The number of staff trained in safeguarding for adults and children did not meet the trust target of 90%. The trust employed a red, amber and green system for monitoring mandatory training for staff. The trust had rated the number of staff trained in safeguarding as an amber risk as the number of staff up to date with training was between 78% and 85%.

Mandatory Training

The pressure to maintain safe staffing levels in the Emergency Department meant not all staff received training in key skills including basic life support training.

The trust had 19 mandatory training subjects for staff to complete. In the Emergency Department (ED) there was only one subject which met with the trust's compliance rate of 90% which was Infection Prevention and Control. The rest of the subjects showed poor compliance, in particular level two paediatric life support at 51.7% and level two adult basic life support at 69.9%. We were told by staff that mandatory training was regularly cancelled due to the pressure to maintain safe staffing levels in the department. The Royal College of Nursing describes mandatory training 'as learning deemed essential for safe and efficient service delivery and personal safety. It reduces organisational risks and complies with local polices and / or government guidelines. The trust was aware of its poor compliance with training. This had not improved since our last inspection. The trust had plans to improve compliance with mandatory training, which was pending approval from the executive leadership team.

The trust was finding it difficult to maintain essential ED training which included plastering, sepsis and triage training. This had an impact on the safety of patients and their timely assessment or triage. We were informed of an incident where there was only one trained nurse who had the relevant training with plastering skills on shift. This could impact on patients receiving timely care.

Urgent and emergency services

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas we visited were visibly clean. The trust used a consolidated scorecard to check the cleanliness of the department.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff being bare below elbows for more effective hand-washing and wearing surgical masks at all times. The results of infection prevention and control (IPC) audit were generally positive. However, hand hygiene audits have not recently been completed.

There was rapid testing for COVID-19. Staff screened patients for signs and symptoms when they attended the ED. Patients who tested positive were isolated or held on ambulances until a space was available. The fast testing laboratory was situated within the emergency department which had a positive impact on the speed of obtaining patient results.

There were COIVD-19 outbreaks in the hospital at the time of the inspection. We saw the separation of negative and positive COVID-19 patients in the area used to treat patients with major trauma and in side rooms.

Staff told us they tested themselves for COVID-19. The Trust had a reporting platform for staff to input their test results so that the trust could check compliance against staff testing. All staff had been offered COVID-19 vaccinations and boosters in line with national guidance.

Where there was no designated COVID-19 toilet, toilets were closed and cleaned after patient or visitor use. We were told by staff the cleaning team were responsive at all times.

Environment and equipment

In times of normal demand and capacity in the emergency department, the design and maintenance of facilities, premises and equipment kept people safe. However, the use of premises during times of excessive capacity pressure did not always keep patients safe. The emergency department had experienced excessive capacity issues since October 2021.

Due to capacity pressures, patients were sometimes cared for overnight in areas not usually used for patient care. This included the back of ambulances and areas in the hospital such as the mental health assessment room. Some patients in the emergency department were cared for in reclining seats and remained in these for long periods of time. Staff carried out criterion assessments for patients and tried to place people in appropriate settings. However, this was not always possible due to the pressure on the emergency department because of the lack of available beds elsewhere in the trust due, in part, to delays in the discharge of patients who were medically approved for discharge.

The minor injury area was seeing patients of greater acuity than the area was designed for. The minor's area did not have the necessary monitoring equipment for the acuity of the patients it was treating nor was the layout of the premises optimal for maintaining the line of sight on patients.

The ED had a designated children's area which maintained children's safety. It included a waiting area, two side rooms and a two bedded bay room. There was no resuscitation trolley in the paediatric ED, however there is one located in the adjacent minor's theatre in addition to the option of taking the patient to a specially equipped and designated bay in the nearby resus. The waiting area for the children's emergency department environment was small and staff told us

sometimes there was only standing room. We were told there was an aspiration to co-locate the paediatric emergency department with acute paediatric assessment unit. The vision is for the Paediatric Emergency department to remain within the ED footprint but work with the acute team to improve patient outcomes. However this aspiration is currently not part of the proposed Women and Children new build.

The children's ED staff had a good working relationship with paediatric ward staff. At times of crowding the Paediatric Emergency Nurses in conjunction with the ED consultant escalate children to be seen directly by the paediatric team after triage in ED. If accepted, then the patient would be sent to the Paediatric unit. General Practice doctors could refer patients directly to the Paediatric unit.

The mental health assessment room was being used to treat clinical patients and therefore the trust did not have a dedicated available room that was equipped to provide a safe and private environment for psychiatric assessments. However, the room did meet with the standards of the Psychiatric Liaison Accreditation Network; for example, it had an alarm strip and call bell running around the perimeter of the room and was ligature free. This was an improvement from the previous inspection.

The main reception area for walk in patients had been fitted with partition shields to help stop the spread of COVID-19 and the seating area had been adjusted to enable social distancing. Seats were labelled to maintain social distancing. We saw numerous posters highlighting the importance of wearing masks and social distancing.

The resuscitation bays were relatively new and fitted with both adult and paediatric equipment. One bay was dedicated for paediatric patients. The new resuscitation bay meant that patients could no longer be cohorted and cared for in the corridors due to a fire risk. This risk was identified during an inspection from the trust fire officer.

Staff completed daily and weekly checks on equipment and consumables. Staff carried out daily safety checks of specialist equipment. All wards and departments we visited had emergency resuscitation trolleys available, except for paediatrics which had easy access to the resuscitation bay. These were locked and secure with tamperproof seals. All checks we reviewed were completed daily with the name of the staff member, date and their signature.

Staff disposed of clinical waste safely. Staff used separate designated waste bins for general and clinical waste disposal. Sharps bins for disposal of needles used for injections were closed and not over filled.

The service had facilities to meet the needs of patients' families, however patients were encouraged to attend by themselves to help reduce crowding and the risk of spreading infection. The hospital closed for visitors on 11 March 2022, once again, due to difficulties with the number of people contracting COVID-19 in the area.

Assessing and responding to patient risk

Staff assessed patients and completed risk assessments for each patient as quickly as practically possible. They removed or minimised risks and updated the assessments. Staff mostly identified patients at risk of deterioration. Audit results for patient safety measures reported poor compliance against national standards in particular for timely care for patients.

The ED was crowded. The Royal College of Emergency Medicine defines ED crowding as prolonged ambulance offload times, long waits for patients to be assessed by Emergency Department clinicians (of greater than 1 hour), delays between request for a bed and that bed being made available (of greater than 1 hour) and a high proportion of patients

in the ED awaiting placement on an inpatient ward. The ED had been struggling with crowding for the past six months, in the main, due to exit block from the ED. In January 2022, Cornwall Council declared a critical incident in adult social care, in part, because there were few onward care packages available in the community; this impacted on the ability to discharge people from hospital.

Patients were in the ED for long periods of time. There was a lack of available beds elsewhere in the trust because wards were closed due to COVID-19, and the trust could not discharge patients who were medically fit for discharge. At the time of the inspection, there were 143 patients classified as medically fit for discharge in the trust. In December 2021, RCHT had one of the highest proportion of patients in the country waiting more than twelve hours from the decision to admit, to admission to the hospital. The trust was also struggling with its ambulance handover times and patients spent a long time waiting in the back of ambulances. On the day of inspection, we reviewed one patient who had been waiting in the ED for 1 day and 16 hours. It should be noted that in November 2021 the unplanned re-attendance to the ED was around 8% which is similar to the England average and suggests when the care was received, it was effective.

In order to help with crowding in the ED, the trust had successfully streamed minor injuries to the community either to GPs or the community minor injury units, except for children. The acuity of patients being seen in the ED had increased. This was, in part, due to the long wait times in the community for an ambulance. It was also due to people presenting to the ED with more severe symptoms because they were scared to access the health care system during the pandemic. RCHT has a higher proportion of major attendances than the England average.

Staff worked hard to manage the needs of patients in difficult circumstances. However, the ED was crowded and the time to respond to patients' individual care needs and provide timely assessments was stretched. Patients were not always getting timely access to specialist nursing and medical care on wards designed for their care needs.

Patients who had 'red flag' symptoms of sepsis such as new onset of confusion or altered mental state, high temperature and fast heart rate were not regularly receiving antibiotics within one hour. In August 2021 only 50% of patients with red flag sepsis received antibiotics within one hour of diagnosis. In November 2021, this was 55% and in January 2022 it was 59%. The national target is for 90% of patients with symptoms of sepsis to receive antibiotics within one hour of diagnosis. Without timely treatment, sepsis can rapidly lead to tissue damage, organ failure and death. Sepsis training for triage and rapid assessment nurses was a contributing factor to why this target was not met. Essential training was often cancelled to meet staffing shortfalls in the department. The trust also stated poor compliance with the national sepsis target was due to delays in getting patients rapidly assessed when the department is busy. This was leading to incomplete screening and missed treatments. The trust is looking at enabling paramedics to administer antibiotics to patients under a Patient Group Directive (PGD). A PGD is a written instruction for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Staff used nationally recognised tools to identify deteriorating patients and escalated most patients appropriately. This included tools to record vital observations which, when a patient deteriorates, medically triggers an alarm to the nurse in charge. This provided the emergency physician in charge (consultant) and nurse in charge with oversight of the clinical risk in the department. Staff completed hourly patient safety checklists. These included pain scores, pressure area assessments and mental health risk assessment scores. We reviewed 10 patient records and saw most patients received care in a timely way once they were assessed, and that patient observations were being carried out within the specified time requirements. However, we found that from the review of care records that most patients were not seen by a doctor within one hour of presenting to the department. In January 2022, there were three serious incidents in ED, two of which related to staff not responding to patients' observations that had deteriorated. An audit of the tool used to

identify deteriorating patients between December 2021 and February 2022 for the ED department showed that whilst 62% of observations were taken within 30 minutes of being due, 83% of observations were taken within one hour of being due. The paediatric emergency department was similar with 69% and 86% respectfully. This meant that some patients were not having observations taken at the required time to monitor their condition.

Patients who arrived at ED were not being triaged and assessed in a timely manner. The national target for patients to be triaged (initial assessment) was within 15 minutes of arrival, however patients were waiting longer than this. In January 2021, the average time for triage was 45 minutes. On the day of inspection, we looked at 5 records and found two patients were not triaged within 15 minutes, one patient was triaged within 20 minutes and the other patient was triaged within 24 minutes. The trust had a rapid assessment and treatment area to help with the triaging of patients waiting on ambulances. Patients could be assessed out of time order if ambulance crew believed they were too ill to wait a further 15 minutes. Considering the activity in the department, staff were calm and methodical when dealing with new patient arrivals. The trust had chosen not to have qualified nurses at reception and reception staff were not provided with additional training in identifying signs of a deteriorating patient as recommended by Royal College of Emergency medicine and as identified in our previous inspection report in June 2021. Reception staff did have access to a doctor if they thought someone looked particularly unwell. With the increased times for patients to be triaged there was a risk a patient could deteriorate in the waiting room before being seen. Patients in ambulances were cared for by ambulance staff qualified paramedics who flagged to ED staff if they deteriorated. The trust were aware of the issue and were trying to prioritise essential training including triage skills for ED staff and also wanted to ring fence a secondary triage room in order to increase the number of people able to carry out triage.

Patients with suspected chest problems did not always receive an electrocardiogram (ECG)(tracing of a heart rhythm) within the specified time window. NICE Guideline CG95 recommends an ECG is recorded as soon as possible at first medical contact (either arrival in the Emergency Department or first contact with pre-hospital emergency medical services). The trust had set a standard for patients with suspected chest problems to receive an ECG within 15 minutes of arrival to the department. For the month of January, an ECG was only performed within 15 minutes for 50% of patients experiencing chest pain. The trust had a system where a health care assistant was alerted when there was a patient arriving who was experiencing chest pain. However, when the department was busy, these staff were often performing other tasks which affected the timeliness of patients receiving an ECG.

Patients who were at risk of pressure sores were kept on trolleys and not beds. The trust has seen an increase in the number of pressure sores. While this cannot be directly attributed to the emergency department, the long periods of waiting on trolleys rather than beds is not ideal. We were told the trust were looking at purchasing mobile pressure relieving mattresses which fitted over the trolley used by the ambulance service. This would be a temporary measure which would help the situation; however, it would be preferable to have available beds for patients elsewhere in the trust. We were told staff tried to move patients at high risk of pressure sores within the ED footprint to a bed if possible. Staff we spoke with in the department were aware of patients at risk of pressure sores and took actions to mitigate the risks.

Staff completed risk assessments for each patient on arrival using a recognised tool and reviewed this regularly. Patients arriving by ambulance were brought into a designated area of the emergency department for rapid assessment and treatment by clinicians. There was no consultant presence in this area. The trust had recently been successful at recruiting four emergency department consultants, and we were told one of these consultants would work in the rapid assessment and treatment area. In the assessment area, time-critical treatment would be given or initiated before patients were moved into the major's area, if there was no available bed space, patients would move back into the ambulance or into cohorting areas. The trust was struggling with administering some time-critical treatment due to the number of patients arriving at the same time.

Patients being held on ambulances were provided with pain relief. We saw patients were able to access medications for any pre-existing illness that became due as a result of the length of time patients were being held on the ambulances.

The service was not using a recognised pain scale designed to assist in the assessment of pain in patients who were unable to articulate their needs, for example patients suffering with dementia.

Treatment of stroke within ED was good when compared nationally with other trusts. For the period 1 January to 25 January 2022, 14.3% of stroke patients were thrombolysed (thrombolysis is a treatment to dissolve dangerous clots in blood vessels, improves blood flow and prevents damage to tissues and organs). The national average was 10.7%. Time critical treatments for stroke patients were also affected by long ambulance waits. The rating of the stroke service had deteriorated but this was as a result of not getting patients onto the stroke ward in a timely manner as no beds were available.

There was a separate electronic system for test investigations such as X-rays, CT scans and blood tests. The Trust was looking to move to a different system where all information will be held on one system.

Reception staff were not trained in dealing with aggressive situations but told us on-site security were available at the department's main entrance between 7pm and 6am every evening and throughout weekends. Reception staff had a panic button to request immediate security assistance. Security staff were available at the hospital main entrance outside of these times and police would also respond if required.

Nurse staffing

The service planned for enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment, however this wasn't always achieved. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift, however this was not always possible. Staff were suffering from the effects of the prolonged pressure on the department. There was a high number of nursing staff leaving the Trust.

The turnover of nursing staff was high and has risen steadily since the end of 2021. In December 2021 and January 2022, over 10% of ED staff left the organisation each month. We were told the number of nursing staff leaving was significant and a real concern for the trust. If the current leaving rate continued, they would be unable to staff the department at safe levels. The percentage of sickness absence relating to stress was also high reaching a peak of 55% of all sickness absence in December 2021. In December 2021 the proportion of staff off sick was 4.94%.

The department had significant numbers of nursing staff vacancies. In March 2022 the number of registered nurses was at 75% of establishment which meant there were 27 registered nurse vacancies. For the same period, unregistered staff such as health care assistants was at 58% of establishment. This meant there were 15 unregistered staff vacancies. The trust had a plan to utilise trained nurses from overseas to help them fill the vacancies.

The required level of nursing staff was not always available to maintain safe staffing levels. The number of trained registered nurses planned on shift was 19. This was an increase of two registered nurses from September 2021 which was agreed by the trust as a result of safety concerns raised from within the department. The number of registered nurses on shift compared favourably to other trusts in the south west considering the size of the ED. When staffing levels did not meet planned levels, the trust tried using contingent workforce bank staff or to redeploy nurses into the department from other areas. Temporary workers (bank and agency) in January 2022 made up over 20% of the ED workforce. When temporary workers could not be engaged, the department worked below the identified establishment. Between 13th December 2021 and 6th March 2022 there was, on average, four unfilled registered nurse shifts each day.

The data for unfilled shifts showed an improving picture month on month from December to March. However, on two days between December 2021 and January 2022, the service had to manage with more than 10 unfilled registered nurse shifts. Staff we spoke to said there was increased pressure and stress when shifts were not filled. They also reported not having the time to complete incident reports.

The minor injury area was sometimes used to treat patients with major injuries and there was not always the number of nurses available for the level of acuity of the patient. At times the minor injury area did not have a nurse in charge on duty. We were told there was a nurse in charge in this area for four days a week between 2pm to 2am. Staff we spoke with said the unit worked better when the nurse in charge was present. In addition, there was not always the number of staff necessary to look after the acuity of the patients being seen. The nurse staffing ratio in the minor's area was six patients to one qualified nursing staff. For patients treated in the majors area, the nurse staffing ratio was four patients to one qualified nurse. The trust did try to increase the staff in the minors area if the acuity of patients was high, however this was not always achieved. There was a protocol to set out the criterion for patients treated in this area. At the time of the inspection the trust were reviewing the staffing model for this area.

The COVID-19 pandemic brought additional pressure to hospitals due to staff either becoming infected by the virus or being required to self-isolate, alongside normally expected sickness absence. The ongoing pressures created by the pandemic meant staff were exhausted and morale was low.

The ED did not have any Emergency Nurse Practitioners (ENPs). An ENP is a senior nurse practitioner specially trained to treat minor injuries without always referring to a doctor. As a result of the efforts to redirect the public to minor injury units (MIUs) the Emergency Nurse Practitioners that were previously based at RCHT ED were deployed to the community MIUs. The clinical strategy is for them to remain in the community. One ENP is based at RCHT. The Trust is reviewing the workforce strategy and requirement for ENP's to work in the department going forward. The children's emergency department recognised that the ability for some nurse led discharges would be beneficial to the flow of the department.

The number of paediatric trained nurses working within the department was compliant with Facing the Future Standards for Children in emergency care settings by the Royal College of Paediatrics and Child Health. The trust rostered two paediatric trained nurses to be on shift at any one time. When this was not possible due to sickness and absence, an adult registered nurse who had basic paediatric life support training was used.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The trust was not at establishment for consultant grade staff at the time of our inspection. We were informed they had been successful in recruiting four additional consultants who were due to start in the following six months. This would mean they would be fully recruited. We were told of plans to have a consultant presence in the rapid assessment and treatment area.

The trust is not at establishment for middle grade doctors with five whole time equivalent vacancies. The Trust has a plan to develop the Certificate of Eligibility for Specialist Registration (CESR) programme as part of the improvement plan to train and retain staff.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The trust employs one Paediatric Emergency Medicine consultant and has recruited a second Paediatric Emergency Medicine consultant who is due to commence employment in July 2022.

Urgent and emergency services

The emergency department had a team of approximately seven advanced clinical practitioners. These practitioners were being trained in emergency medicine by the Royal College of Emergency Medicine. Advanced clinical practitioners eventually work at the level of a middle grade doctor once qualified.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff speaking to patients kindly.

Patients said that staff were kind and kept them up to date with their treatment plan. Patients recognised how hard staff were working and appreciated their effort to make them as comfortable as possible.

Staff treated patients with respect and dignity. An urgent and emergency care survey carried out with patients receiving care between November 2020 and March 2021 rated the care they received at the department as nine out of 10 for being treated with respect and dignity'.

Staff mostly understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. However, we witnessed a conversation in a cubicle about retrieving staff property from a mental health patient. Several members of staff and patients were able to hear this and this could have been dealt with in a more sensitive manner. Staff, at times, choose to treat mental health patients in cubicles as they felt this was a safer environment.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients with learning disabilities or who needed extra support were able to be accompanied by a carer or family member to support them.

Is the service responsive?

Inspected but not rated

Access and flow

The trust faced challenges with access and flow which meant they could not always ensure patients accessed the emergency department when needed, or ensure they received timely treatment. Most of the issues causing the challenges for the emergency department were beyond the control of both the emergency department and the trust. Delays were seen for patients waiting to be seen and treated as well as in admission to the hospital from the emergency department. Staff risk assessed patients who attended the emergency department and treated those with urgent needs promptly.

Urgent and emergency services

Managers monitored waiting times and adapted services to support patients' access to emergency services. The emergency department collected data and monitored how many patients were in the department, how long they had been there and how many ambulances were queueing to handover patients. This data was reviewed continuously by the emergency physician in charge and the nurse in charge/coordinator. As reported in the 'safe' section of the report above, the department was not meeting the national standard for triage, the national standard for 'red flag' sepsis patients nor the recommendations for patients with chest pains to have access to an echocardiogram within 15 minutes of arrival in the emergency department.

There was a lack of available beds elsewhere in the trust for patients awaiting admission from the ED. At the time of the inspection, there were 143 patients classified as medically fit for discharge in the trust that remained in the hospital taking up beds on the wards. There is a national target to discharge, admit or transfer 95% of patients within four hours of arriving in the ED. Against this metric, the trust achieved 52% in January 2022. In total, in January, there was a total of 2,406 breaches of the four hour target. Patients waiting for a bed in the trust made up 44% of these breaches. In December 2021, this figure was 45% which was the worst performance of any trust in the south west region.

Patients had long waits in ambulances outside the ED due to the lack of available beds in the department. According to the Association of Ambulance Chief Executives in December 2021 many of the indicators relating to handovers suggest delays at the Trust were the longest in the country. Ambulance handovers were not in line with the national standards where clinical handover and offload are to be completed within 15 minutes of arrival. These delays also negatively impacted the ambulance service ability to respond to emergency calls in the community.

Patients had long waits in the emergency department. The trust had many patients waiting over 12 hours in the emergency department from decision to admit to admission. In December 2021, 30.7% of attendances were waiting more than 12 hours from decision to admit to admission which is one of the highest percentages in the country and compares unfavourably to the south west average of 7.1%. The trust continues to have issues with patients spending a long time in the emergency department with 471 reportable 12-hour trolley wait breaches in January 2022.

The service had a same day medical assessment unit (SDMA) that was supposed to be ringfenced in order to treat medical patients requiring same day treatment. It was run by the medicine department (please see medicines report). One of the aims of this service was to help reduce activity in the emergency department and thus help with capacity. However due to the lack of available beds, the SDMA sometimes turned into an area where patients were cared for overnight. On the night of the inspection the SDMA was being used to care for two patients overnight. The use of the SDMA as a bedded unit meant more patients had to be seen in the emergency department. The available space and performance of the SDMA was not visible to emergency department staff. Orthopaedic and trauma patients were also managed through the emergency department.

The trust had streamed most minor injury patients to different services in order to try and alleviate the pressure in the emergency department. The triage nurse had a standard operating procedure to follow when redirecting patients to other units or to other inpatient specialities. Patients could be referred to their GP's or referred to the Minor Injury Units in the community. Certain criterion of trauma patients were referred to St Michaels Hospital or West Cornwall Urgent Treatment Centre. Elderly and frail patients who fit certain criterion could be referred to the Community Assessment and Treatment Units (CATU) based at West Cornwall Hospital, Camborne Redruth Community Hospital, St Austell and Bodmin Hospitals. These centres were all created during the pandemic and were designed to prevent inappropriate ED attendance and subsequent acute admissions by providing GP's, Community Nurses, the ambulance service, community therapy teams and minor injury units with alternative pathways. There was a helpline available to care homes to enable their residents to be directly admitted to the CATU.

Urgent and emergency services

The trust ran a frailty service designed to help access and flow by providing a screening system for unscheduled admissions and identifying and coordinating transfers to the CATU for the frail and elderly. Staff we spoke with were positive about the service. Quality reports for the service show they increased the number of patients screened month on month from 255 patients in November 2021, to 418 patients in February 2022. The team was staffed with just less than three whole time equivalents who cover from 7.30am to 3pm five days a week. The trust was in the process of recruiting to one vacancy and are looking to expand the service to seven days a week.

The trust had improved its performance for the average time from arrival in the emergency department to treatment over a number of months. The national standard is 60 minutes. Although the trust was not meeting this standard recording an average time of 63 minutes in January 2022, the trust was performing favorably against the national and south west region as a whole.

Children brought in by ambulance were brought to the children's emergency department. It was also possible for children to be referred directly to the paediatric ward avoiding the need for them to attend the emergency department. There was always one bay in the resuscitation area prioritised for children.

The trust stated that discharge planning started on admission and all patients were to have an expected discharge date. The trust had a workstream to improve the aspects of flow in the hospital for the areas which were within its control. This included the introduction of nurse led criterion-based discharge and a plan to implement processes to support and monitor weekend discharges. The service also reviewed long stay patients. This was in its infancy at the time of the inspection.

Complaints

The emergency department was not responding to complaints in a timely manner. For the months September 2021 to February 2022 the service had managed to respond to 65% of complaints within the trusts agreed timescales. The response time to complaints was raised as an issue at the previous inspection in December 2019. The trust was supporting the ED to improve its response time but as a result of the pressure on the ED staff were required for frontline work and this was impacting complaint response times.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were mostly visible and approachable in the service for patients and staff. There were plans for staff to develop their skills and take on more senior roles, but current service pressure was preventing this from happening.

The leadership of the emergency department comprised a Service Manager, Deputy Head of Nursing, and a Clinical Specialty Lead. The Clinical Specialty Lead was currently deputising for Clinical Director on behalf of the emergency department, leading all staff including the consultants, middle grade, and Junior Doctors. The Service Manager covers the emergency Department, acute medicine and major trauma.

The leadership were supported by a Care Group General Manager, Head of Nursing and Clinical Director. However, at the time of inspection this post was vacant.

Urgent and emergency services

The department leadership team were committed to safe patient care and supporting their staff. They were able to articulate the challenges within the department and gave us good examples of when issues were escalated to senior leadership and the actions they have taken. For example, the increase in the registered nursing staff in September 2021 from 17 to 19 was a result of the team feeding concerns to the senior leadership team in order to improve the safety of the department.

Staff we spoke with said the immediate leadership team was visible, but this was not the case for some of the senior management team. The lack of continuity in terms of the chief executive and medical director was also cited as having a negative impact on staff.

Staff were not receiving the necessary support to develop their skills. The leadership team knew the importance of staff attending training as well as the influence this had on the retention of staff. We were told the priority was the safe staffing of the department ahead of staff training. This resulted in mandatory and essential emergency department training being cancelled. Post inspection, we were told the trust were developing a recovery plan to enable staff to attend essential training.

Culture

Staff were respected and valued however working in a crowded environment for a long period of time meant that staff were also exhausted and stressed. Staff were focused on the needs of patients receiving care and at times felt isolated from the leadership team.

Staff were working under relentless pressure. We saw they were a strong team, working to support each other and with a dedicated work ethic which meant they looked after each other during and after challenging and exhausting shifts. Staff sickness due to stress was an issue as well as staff (mainly nursing staff), leaving the trust. The leadership team had referred the whole of the nursing staff to occupational health for stress assessments. Staff had access to a 24 hour counselling hotline and resilience training workshops were being planned to help improve staff welfare. A group of staff members were also being trained in a trauma-focused peer support system that was designed to help staff who have experienced a traumatic, or potentially traumatic event.

Most staff were not receiving annual appraisals nor career development conversations. The number of staff receiving appraisals steadily declined across the year and was currently at its lowest in January 2022 with only 50.9% of staff receiving an annual appraisal.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The emergency department had a risk register which fed into the trust wide risk register. The leadership team reviewed risks regularly at Governance and Quality Meetings held monthly. New risks were discussed and added to the risk register. For example, in February 2022 the management team added emergency department staffing (mainly nursing) as a risk. This was as a result of the number of nurses leaving the trust. The safety meetings were attended by the clinical governance lead, all emergency department staff as well as speciality consultants, service leads, allied health professional representatives and specialist nurse representatives.

Urgent and emergency services

Staff reported frustration with incident reporting and said they didn't always formally report incidents when they happened. Staff said incident reporting took too long and that incidents were used by other departments as a way to criticise the care patients had received in the emergency department. When staff report incidents they are directly contributing to potentially preventing a future incident from happening again; the lack of incident reporting is therefore a concern.

The department had a number of protocols, escalation plans and standard operating procedures for when seriously ill patients, who would usually be placed in the major unit of the emergency department, were placed in the minors area. All these procedures and guidance were being used by staff who were managing the needs of the patients to their best ability. It should be noted that these policies were escalation policies intended to be used when ED was stretched. However, it was clear that in the last six months, this was the 'business as usual' position.

There was a plan to improve the flow of patients through the trust which included the ring fencing of the Same Day Assessment Unit as well as the review of long stay patients and working on criterion-based discharges. Unfortunately, the number of patients without an onward package of care and the impact of COVID-19 on staff and patients was not something the trust could directly control.

There was no quality dashboard in the ED department to feedback performance to staff. Quality dashboards are a type of health information technology that use data visualization techniques to support clinicians and managers in viewing and exploring data on processes and outcome of care.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The trust must ensure care and treatment is provided in a safe way for service users. The trust must assess the risks to health and safety of service users receiving the care and treatment and doing all that is reasonably practicable to mitigate any such risks. All patients attending the department must receive all care and treatment in a safe and timely way in line with clinical guidance and in an area of the department where it is safe to do so. The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. Ensure patients are admitted from the emergency department to a ward bed in a timely way. Ensure patients do not experience long waits for treatment in ambulances to reduce the number of ambulances being held at the emergency department. **Regulation 12 (2) (a) (b) (c) (d)**
- The service must ensure it has sufficient numbers of staff for the minor injuries or illness area when it is used for patients with major injuries or illness. **Regulation 18 (1)**

Action the trust SHOULD take to improve:

- The trust should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Cornwall.
- The trust should plan to improve the retention of staff in the emergency department and mitigate any risks from an inexperienced workforce.

Urgent and emergency services

- The trust should complete hand hygiene audits in the emergency department.
- The trust should protect the Same Day Medical Assessment Unit in order to relieve pressure on the emergency department. The trust should consider alternative pathways for other specialities to avoid patients attending the emergency department.
- The trust should consider expanding the frailty teams to cover additional hours and weekend working.
- The trust should operate an effective and accessible system for identifying, receiving, recording, handling and responding to complaints.
- The trust should ensure that staff report and learn from incidents.
- The trust should consider using a tool that is designed to assist in the assessment of pain in patients who are unable to articulate their needs.
- The trust should consider how to ensure the mental health assessment room is used for its intended purpose.

Medical care (including older people's care)

Inspected but not rated

Royal Cornwall Hospitals NHS Trust (RCHT) provides medical care services for adults and children. It is open 24 hours a day, seven days a week. The trust is the only acute hospital serving the county of Cornwall and the Scilly Isles.

Since the start of the COVID-19 pandemic some medical care services at Royal Cornwall Hospital have been reconfigured to accommodate and cohort patients who tested positive for COVID-19.

Total medical attendances at RCHT between December 2020 and November 2021 were 59,995 which was a 6% increase from the pervious year.

Is the service safe?

Inspected but not rated

Inspected but not rated

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas we visited were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Any areas that were rated as 'red' or not been cleaned to the standard required were documented and reported back to staff concerned to address. Hand hygiene audits demonstrated staff were mostly compliant. If any areas had not completed audits or areas for improvement were identified, an action plan was devised and staff were allocated to address the shortfall.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing face masks, aprons and gloves when required in line with national guidance. Hand gel dispensers were full, and we saw them in all areas we visited. Information on how staff should wash hands was provided in ward areas. We observed staff washing their hands frequently or using the hand gel.

There were designated wards for patients who had tested positive for COVID-19. However, during our inspection, the trust had an outbreak of COVID-19 which had resulted in several medical wards and some of the bays on other medical wards being closed to prevent further spread. Senior staff told us they reviewed all outbreaks and found most patients had tested positive on their routine inpatient swabbing.

COVID-19 testing was undertaken at set days on inpatients and staff took appropriate action if a patient tested positive. Staff were encouraged to test themselves twice weekly and report to the nurse in charge if they tested positive.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Medical care (including older people's care)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. However, the use of some of the escalation areas meant not all had facilities for personal care. Staff managed clinical waste well.

Patients could reach call bells and most staff responded quickly when called. The delay was often due to staff attending to other patients. In the discharge lounge, which was being used for inpatients, staff did not always have sight of patients in the end bay which meant they had to make sure they were monitoring this area. Senior staff confirmed this happened.

When patients were cared for in the escalation areas, staff assessed patients to make sure their needs could be met whilst being cared for in these areas. Staff told us the hospital had a policy for using these areas and understood how to implement this policy.

Staff carried out daily safety checks of specialist equipment.

The service had enough suitable equipment to help them to safely care for patients. However due to issues with storage we saw equipment was stored in some of the hospital corridors, for example, beds and trolleys. We also saw outside of the Acute Medical Unit (AMU) walking frames, weighing scales were being stored which could be a fire risk. This was immediately removed when we highlighted it to senior staff.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This included recording physical observations; for example, blood pressure, pulse and respirations. This information was stored electronically, and staff told us they knew when they had to call for a medical review.

Sepsis audits demonstrated 100% compliance with all patients being screened. However, not all patients received their anti-biotics within the one-hour of diagnosis as per the national target. For December 2021, it was 83% and for January 2022, it was 71%. An action plan had been devised which included, support to the wards from the sepsis nurse where they were not meeting the target and a combination of online and face to face sepsis training.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff showed us these risk assessments on the handheld electronic devices they used. They told us they updated risk assessments frequently and following any changes in condition.

Staff knew about and dealt with any specific risk issues, for example, pressure ulcers and falls. Staff had access to pressure relieving equipment for patients assessed as being at risk. Patients were also assessed for their risk of falls. Staff told us patients at high risk of falls would be cared for near to the nurses' station or in a bay with staff present most of the time.

The service had 24-hour access to mental health liaison if staff were concerned about a patient's mental health. Mental health support was provided by another trust. We met one nurse who specialised in dementia care and they told us they reviewed all patients who were over the age of 75 and those who had dementia. This service was provided five days per week.

Staff shared key information to keep patients safe when handing over their care to others. However, prior to this inspection we had received details that not all information had been shared with other providers of social care services, care and nursing homes. For example, information about a patient's specific care needs. Their relative had to contact a member of staff from the ward to find out this information on behalf of the care home. Individual incidents had been investigated by the trust and where any actions were needed, action plans were devised.

Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix to try and meet the required safer staffing levels but this was not always possible. Bank and agency staff had a full induction.

Due to national shortages of nursing and support staff and high levels of staff absence, the service did not always have enough nursing and support staff to keep patients safe. Senior staff told us they were continuing to advertise vacant posts for registered nurses and health care assistants. Staff told us they were often short staffed, or they had to be moved to other wards to cover any gaps in duty rotas. Staff said they understood why they were moved but said it was often unsettling to work on unfamiliar wards. Senior staff told us they had a safer staffing meeting each day to look at the number of staff they had on duty and where they had any gaps. Staff would be moved to make sure all wards/areas were safe. Senior managers acknowledged staff did not like to be moved but said they had to consider the safety of patients across the hospital.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior staff on the wards told us they could adjust the staffing if they had patients with additional or higher care needs that required staff to be always in the patient bays. However, they could not always fill these extra shifts or staff were moved to fill in gaps on other wards. This meant some patients did not receive the level of care they required.

The ward managers could adjust staffing levels daily according to the needs of patients. We were told some staff were moved from the acute medical unit (AMU) to cover the cohort escalation area based in the emergency department. An acute admissions unit is a short-stay department for medical patients where their plan of care and treatment is devised before sending them onto a medical ward specialising in their condition. This meant the AMU were short staffed and they had to cover breaks in the cohort escalation area which reduced their staffing numbers further which could potentially place patients at risk of unsafe care.

The number of nurses and healthcare assistants did not always match the planned numbers. We saw the planned and actual numbers on display outside each of the wards we visited, and we found not all of these had the required numbers of staff. Some areas were short between one to three staff which had an impact on patient care and workload for staff.

Medical care (including older people's care)

The service had a process for the use of bank and agency staff on the wards to fill in any vacancies. Managers would request staff familiar with the service if possible and made sure all bank and agency staff had a full induction and understood the service. This process sometimes impacted ward staff as it took time to induct staff not familiar with the ward.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe for most of the time. Some medical staff told us they did not feel they had enough staff to cover the demand for their services especially in the emergency department (ED) or when cohort areas were used. Some wards were closed due to COVID-19 and many patients who were medically fit for discharge could not be discharged safely due to a lack of social care packages.; This meant wards had lost some of their speciality focus and some medical staff took extra time trying to find their patients for wards rounds.

The service had low vacancy rates for medical staff but had a high vacancy rate in neurology.

Sickness rates for medical staff varied between the medical specialities with some having higher sickness rates than others. For example, the trust sent us details about sickness rates and it was 16% in January 2022 for junior medical staff in neurology.

The service had low rates of bank and locum staff use. Managers could access locums when they needed additional medical staff. The service always had a consultant on call during evenings and weekends. Therefore, junior medical staff could contact them for advice and support.

Medicines

The service had systems and processes to prescribe, administer, order and record medicines safely.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely. Access to treatment rooms was restricted to appropriate staff. Controlled drugs were stored and managed appropriately. Regular balance checks were performed in line with trust policy.

There was a dedicated medicines area for the discharge lounge which was located on the Same Day Medical Assessment unit (SDMA). By design as all ward areas across the trust had one medicines prep area and the discharge lounge was currently located on SDMA. Staff could order medicines through the Pharmacy Order Portal. This allowed for quicker delivery from the inpatient pharmacy.

Patient Group Directions (PGDs) were in use and there was a procedure in place to review them. PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines in the absence of a written prescription.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Medicines were regularly reviewed by ward pharmacists. Pharmacists were available to speak to patients who needed advice or had concerns about their medicines. Information about medicines was available in a range of formats, for example large print, easy read, very easy read, different languages.

Medical care (including older people's care)

We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them.

Guidelines and protocols were in place to support prescribing decisions. However, we saw one person who was prescribed an intramuscular antipsychotic medicine for symptoms of delirium, where prescribing did not follow NICE clinical guideline CG 103.

Staff stored and managed all stock, patients own medicines, and prescribing documents in line with the provider's policy. Access to medicines was restricted to authorised staff. Daily checks made sure that room and fridge temperatures were in range and these were recorded.

Controlled drugs were stored securely and recorded appropriately.

Emergency medicines were stored securely, tamper evident and in date.

The electronic prescribing and medicines administration (EPMA) system was password protected and secure. Other prescription stationary was stored securely.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet.

Patient's medicines were reconciled in line with current national guidance on admission and when transferring between locations.

The pharmacy department worked with local system partners to ensure that patients who needed additional support or review after discharge were able to access community pharmacies for a medicines review. Evaluation indicated that this had a positive benefit on reducing re-admissions due to medicines issues.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The Trust acted rapidly to ensure patients were kept safe considering alerts or highlighted risks. In addition to this practice, the trust proactively used electronic systems to complete internal audit into prescribing so that actions could be taken quickly to advance practice and support ongoing learning. Staff knew how to report medicines incidents or near misses via the trust's electronic reporting system. Staff we spoke with felt confident in raising an incident should they need to. The trust medicines safety officer shared learning around medicines incidents.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. However, prescribing of an antipsychotic for one person with delirium had not been reviewed in line with best practice. When this medicine was administered, post-dose observations were not formally taken or recorded.

Is the service effective?

Inspected but not rated

Medical care (including older people's care)

Inspected but not rated

Patient outcomes

Staff monitored the effectiveness of care and treatment. Outcomes for stroke patients did not always meet national standards.

The service participated in relevant national clinical audits. We examined The Sentinel Stroke National Audit Programme (SSNAP) data for stroke patients. This showed from July 2021 to September 2021 this trust admitted a lower proportion of patients directly to a stroke unit compared to the national average. The trust also had a longer median time from when patients arrived at the hospital and the clock started, until their arrival at the stroke ward compared to the national average. This hospital recorded the lowest rating of 'E' by SSNAP for the stroke domain unit. This meant the hospital had the worst rating for patients being transferred to the stroke unit within the target time. This was mostly due to the high number of medical outliers admitted to the stroke unit and increased demands on the emergency department services which delayed patients being admitted to the stroke unit.

We followed two patients journey from the ambulance through the emergency department (ED). We observed good assessment of their symptoms and then onto radiology for a CT scan. One patient had a delay in waiting for the CT scan as we observed radiology did not appear to prioritise all requests. There was a team of six nurses who specialised in stroke care who covered for 24 hours per day. They would review all patients who were admitted to the ED with the medical team.

There was a designated stroke ward (Phoenix) where most stroke patients were admitted to once they had been assessed through ED. This ward had a multi-disciplinary team of staff to provide patients with treatment. Patients had a length of stay for about six days and in this time, they underwent therapy and investigations. Following this and when the patient was ready, Phoenix ward staff worked to discharge the patient to either their home or to other health care settings.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us they discussed each patient at these meetings, for example, ongoing treatment, and new issues or concerns and discharge plans. Other professionals were involved in most patient's care, for example, physiotherapy.

We observed good multi-disciplinary working in the ED when stroke patients were admitted. This included the ambulance service, ED staff and the stroke team.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, staff on Phoenix ward worked closely with external rehabilitation teams in the community or at community hospitals to support patients once they were discharged.

Staff liaised with other health and social care providers to plan ongoing care. The discharge liaison team reviewed all patients who were waiting for ongoing care and discussed them with the relevant health or social care provider.

However, we received information prior to and just after this inspection that some care and nursing homes were not receiving information from some wards about the patient's needs on discharge to them. This potentially placed patients at risk of unsafe care and treatment. Some of this information was sent to the trust by a patient's family as a formal complaint and we have requested a copy of the outcome into the concerns raised.

Patients had their care pathway reviewed by relevant consultants during ward rounds and any changes to their care and treatment was documented in their records.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including at weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The discharge liaison team worked seven days per week but access to social care providers was limited to an on call service at the weekends. This meant it was often difficult to discharge patients who required social care support at weekends if this had not been booked in advance.

Is the service caring?

Inspected but not rated

Inspected but not rated

Due to the outbreak of COVID-19 we were not able to visit all the medical wards and the number of patients' we spoke with was limited.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way.

Prior to this inspection we received information that not all staff on Tintagel ward treated patients with respect and kindness. Tintagel ward cared for older patients with general medical needs and patients who had neurological conditions. Due to COVID-19 Tintagel ward was closed therefore, we were not able to observe how staff interacted with patients. We spoke with a senior member of staff who told us following our feedback they had a staff meeting to discuss the concerns received and they will monitor the situation.

Medical care (including older people's care)

Patients said staff treated them well and with kindness. We observed this when we visited the wards.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff told us they had access to a translating service if they had a patient whose first language was not English.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff told us they included the patient's family when discussing their condition, treatment and ongoing plans. However, prior to this inspection we received information that not all families felt included in any ongoing plans on Tintagel ward. Due to the ward being closed we were not able to follow up on this concern. A senior member of staff told us they were working with the staff on the ward to address the concerns raised.

Patients and their families could give feedback on the service and their treatment. Information about how to do this was displayed on the wards and around the hospital.

Patients gave us positive feedback about the service during the inspection.

Is the service responsive?

Inspected but not rated

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. However, due to increased capacity pressures on their services and bed availability, some patients were cared for in areas that did not have all the amenities required to meet their needs.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During our inspection we did not see any breaches of mixed sex accommodation.

Facilities and premises were mostly appropriate for the services being delivered. Due to the increased capacity pressures on their services and bed availability, some patients were being cared for in areas that were not designed for overnight stays. For example, the discharge lounge as they did not have access on the unit for showers or bathing.

Staff could access mental health support 24 hours a day, seven days a week for patients with mental health problems.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention. There were specialist nurses who could provide support and guidance for staff for example, sepsis nurse and stroke nurses.

The service relieved pressure on other departments when they could treat patients in a day. The same day medical assessment unit (SDMA) would see patients who had been referred by their GP or admitted via a clinic to prevent them waiting in the emergency department.

Meeting people's individual needs

The trust was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, due to increased capacity pressures on their services and their bed availability, not all patients were cared for on a ward that treated patients with the same speciality.

Due to pressures on capacity and bed availability, some patients were cared for on a medical ward or in escalation areas which did not specialise in their medical condition. For example, about 30 patients were waiting for a bed on the cardiac ward during our inspection. These patients were also waiting for cardiac investigations.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us they were able to obtain advice and support from specialist nurses if required in relation to dementia, learning disabilities and mental health.

Wards were not all designed to meet the needs of patients living with dementia. However, on the acute medical unit (AMU) they had an area for people over the age of 75 years. The staffing for this area was multi-disciplinary, for example, medical staff, nurses, occupational therapy and dieticians. There was also access to a dedicated psychiatric liaison who specialised in dementia care for people over the age of 75 years.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they were aware of how to contact interpreters for patients and their relatives whose first language was not English.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us the trust was able to provide leaflets to meet the needs of their patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us if any patients had any special dietary requirements, they would contact the catering team.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on services and bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages. Some patients were being moved between wards and areas, sometimes at night, to meet the demand for beds. Some patients were needing longer stays while they awaited treatment.

Medical care (including older people's care)

The hospital had significant capacity problems with a lack of available beds. They had 143 patients who were medically fit to go home, but there was no social care package immediately available or care/nursing home able to meet their needs for discharge to be carried out safely. There was also a delay in accessing some community hospital beds due to the demand on services. The situation was made worse by the increase in patients testing positive for COVID-19 which had led to some medical wards being closed. Other wards had bays closed to prevent further outbreaks.

Patients were often delayed for discharge due to reduced capacity with social care. There was a lack of domiciliary care packages for patients who had complex needs and required frequent visits throughout the day. This was due to staffing shortages. Some patients' discharges were delayed due to lack of specialist care in a nursing or care home for patients with mental health care needs. We were told about a patient who had been in hospital for several months as they could not find a nursing home that could meet their needs. This patient was now unwell and not medically fit for discharge due to the delay.

The trust had offered a financial incentive to relatives to take home patients who needed less domiciliary support for example, only one or two visits a day. Some families were able to accommodate this to help free up hospital beds.

Senior staff monitored the number of delayed discharges. Patients who were medically fit were identified on their computer system and were followed up each day with ward staff. The discharge liaison team worked with other providers to look at how to discharge some of these patients. For example, they worked with another local NHS trust to move patients to community hospitals to help free up acute beds in the hospital.

Schemes to prevent admission or support early discharge were being introduced. Senior staff told us about a new initiative supported by this trust and other providers from health and social care. A team of nurses will support nursing and care homes with patients they have concerns about meeting their needs. This team will also be able to visit the emergency department and support care/nursing homes to re-admit their residents with support from them. This scheme was to help reduce admissions to hospital. As this was in its infancy there was no information on how it was working at the time of our inspection.

Managers and staff started planning each patient’s discharge as early as possible. However, when we spoke with staff on the wards, not all were familiar with the estimated date of discharge and how they should use it. The purpose of an estimated date of discharge is to help with planning a patient’s care and treatment and to make sure any additional support was identified and provided on discharge. Senior staff told us they needed to improve staff awareness of discharge planning. They were also looking to introduce nurse led discharges with a set criteria as this worked well in some surgical specialities and may help to speed up some discharges.

The Acute Medical Unit (AMU) was meant to be a short stay unit where plans for patients' treatment and care were devised and then the patient was transferred to the ward able to care for their specific medical need. Due to the increased pressure on bed capacity this was not happening. We saw one patient had been on this unit for nearly two weeks.

Patients were delayed waiting for cardiac investigations which also impacted on bed capacity. This was due to the pandemic and reduced capacity during this period. The trust was now trying to catch up with the back log of both elective (planned) and emergency cardiac investigations. During the inspection we were told 30 patients were waiting for cardiac investigations on medical wards as there were not enough beds available on the cardiac ward. Patients were not always able to be discharged home to wait for their cardiac investigations as they were unwell. A number of patients in the community were also waiting for cardiac investigations.

Medical care (including older people's care)

Patients often experienced a delay in having their care and treatment reviewed by medical teams. Medical staff told us that due to increased pressure on their services, not all patients were being cared for on the speciality ward for their medical condition. This meant they took additional time to find and review their patients which had an impact on any possible discharges.

Managers monitored patient moves between wards at night. From September 2021 to February 2022, 303 patients were moved at night between the hours of 10pm to 8 am. Most patient moves happened at 10pm to try and free up beds ready to transfer patients out of the emergency department (ED).

Managers monitored waiting times and aimed to make sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, due to the increased capacity pressures on their services, it was not always possible to do this. Senior staff in medical care were aware of the status of the service.

Senior staff participated in site meetings which were held frequently throughout the day. During these meetings senior staff discussed operational issues; for example, the number of patients waiting in ED to be provided with a bed, the number of beds they had in the hospital, the number of planned discharges and how many beds were closed due to the COVID-19 outbreak.

Managers worked to minimise the number of medical patients being cared for on non-medical wards (known as outliers). They were discussed at each site meetings throughout each day. Due to bed capacity issues, moving medical outliers to medical wards proved challenging due to limited capacity which was exacerbated by an increase in COVID-19 cases. Arrangements had been implemented for medical staff to review any medical patients on non-medical wards and this was communicated to all staff.

There was a process for arranging transport when patients were moved to the other hospitals. A member of staff from the transport provider was on site at Royal Cornwall Hospital. They were able to arrange transport quickly and inform the staff on the wards when this would happen so patients were prepared and ready to prevent any delays.

Is the service well-led?

Inspected but not rated

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were mostly visible and approachable in the service for patients and staff.

The medical care service had a clear senior management leadership structure. The leadership of the wards was overseen by matrons and each ward had a manager. For medical staff, a lead medical consultant had oversight of medical care.

Leaders had the skills and abilities to run the service and they were committed to providing safe patient care and supporting their staff. Leaders were aware of issues which included delayed discharges impacting flow and the increased pressures on available beds, but they were working hard to maintain patient safety.

Medical care (including older people's care)

Staff we spoke with said they saw their immediate leadership team frequently. However, this was not the case for some of the senior management team. Some staff told us the number of changes to the chief executive was having a negative impact on staff due to a lack of consistency. Although the chief executive had visited the emergency department and met with leaders, some staff were not aware of this and indicated they would like more of a presence at times of high demand on their service. The Dual Director of Nursing, Midwifery and Allied Health Professionals /Deputy Chief Executive Officer, Chief Operating Officer, and Director of Operations visited the medical wards, escalation areas and emergency department frequently to support staff during this period of excessive demand on their services.

Leaders told us they wanted to support staff to have the best working environment they could despite the pressures on their services. Most staff we spoke with were positive about working in the hospital and morale appeared to be good. Some staff told us about ideas they had to help improve flow, but they felt they were not able to share these with senior staff at board level.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The trust had systems for recording, reviewing and managing risks. There were three risk registers which included medical care. Acute Medicine had their own risk register, although there were some defined risks that spanned across both areas i.e., crowding in the emergency department. There was another for medical care and one for speciality medical care. Each risk register was comprehensive, each risk had been given a score depending on the level of risk and these were reviewed regularly. Some risks related to the capacity in their service and the impact on flow through the hospital and patient care. Leaders in the service attended governance meetings where risks to the service were discussed. Board members were aware of the extreme risks, and these were reviewed by them monthly.

The trust had devised a flow programme and seasonal plan to help improve the flow through the hospital. There were three main workstreams related to flow. This was a new plan and was only in its infancy therefore we did not have any feedback on its progress at the time of the inspection

Senior staff from the trust took part in several times a day site meetings. These meetings focused on trying to improve the flow through the hospital to try and find beds for all the patients waiting for beds.

Senior staff from the trust met regularly with other stakeholders and partners from health and social care to discuss the risks to the system as a whole and to look at identifying solutions.

Areas for improvement

Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

Medical Care

Medical care (including older people's care)

- The trust should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Cornwall
- The trust should review the process for cardiac investigations out of hours to prevent the Coronary Care Unit (CCU) from having to release a member of staff to cover this and to maintain safe staffing levels on the CCU.
- The trust should ensure they work with staff to understand the use of the estimated date of discharge and the purpose of this.
- The trust should continue to look at devising a criteria for nurse led discharges in medical care to help with flow through the hospital.
- The trust should look to protect areas like Same Day Medical Assessment Unit from being used as escalation areas to help maintain flow through the hospital and to reduce the impact on Emergency Department from medical patients.
- The trust should ensure that prescribing, monitoring and review of antipsychotic medicines follows best practice.
- The trust should review the medication arrangements for the discharge lounge as they do not have access to their own stock of medicines.
- The trust should ensure all information about patients care needs is sent to care/nursing home when the patient is discharged.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, an inspection manger, an inspector and two specialist clinicians. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing