Care Quality Commission

Royal Cornwall Hospitals NHS Trust

West Cornwall Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Medical care (including older people's care)	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. The Trust is not a Foundation Trust and performance is monitored by the Trust Development Authority (TDA).

The Trust serves a population of around 450,000 people, a figure that can be doubled by holidaymakers during the busiest times of the year.

This is the second comprehensive inspection we have carried out at Royal Cornwall Hospital NHS Trust. The first being in January 2014 when the Trust was rated as requires improvement. In June 2015 we carried out a follow up to the first inspection and found the trust had not made sufficient progress in all areas and a second comprehensive inspection was required.

Our key findings for West Cornwall Hospital were as follows:

Safe

- There was a positive approach to incident reporting with evidence of learning from within and external to the ward and hospital. Patients were informed by staff when things went wrong and given an apology.
- There were reliable systems in place to prevent and protect people from a healthcare associated infection and equipment was checked and maintained.
- There were sufficient nursing and medical staff to meet patient needs

Effective

- Staff provided evidenced care and treatment. The endoscopy unit had received JAG accreditation and the renal unit had started to deliver haemodiafiltration to improve patient outcomes.
- There was a strong focus on multidisciplinary working.
- Staff had a good understanding of the mental capacity act and its application in practice.

However,

- Not all staff had received annual appraisals with one ward reporting only 8% of staff having had an appraisal in the previous twelve months.

Caring

- Staff were seen to deliver care that was kind and compassionate and at times went the extra mile to care for both patients and relatives. Emotional and spiritual needs were met.
- Patients were highly positive about the care and attention they received.

Responsive

- Services were planned to meet the needs of patients and visitors to the area.
- Discharge planning commenced on admission.
- Staff at the hospital went to great lengths to plan, deliver and coordinate care and services in a way that took into account patients' complex needs.

However

- It was not clear how patients or relatives could raise a concern or a complaint.

Well led.

Summary of findings

- There were governance systems in place that ensured activity was monitored, risks were reflected on the risk register and findings were fed into the trustwide governance system.
- There was an open culture with a visible leadership where staff felt able to raise concerns.
- There was innovative working and close engagement with the local community. Recruitment and retention strategies were in place.

We saw several areas of outstanding practice including:

- The hospital worked closely with Age UK to provide additional services to patients on discharge. This ensured their home was ready for them when they returned. Their presence within the hospital also supported the care of patients living with dementia.
- Staff went the extra mile for example by providing a 'memory café' in the day room on a weekly basis. Patients and family members could attend for free and were invited to engage in singing, quizzes and games to help engage people living with dementia. Patients received tea and homemade cakes made by the nurses, along with prizes.

However, there were also areas of poor practice where the trust needs to make improvements.

The trust should:

- Ensure the decontamination room and storage room used by the endoscopy service is kept secure at all times.
- Ensure there is a system to monitor staff accessing clinical supervision.
- Ensure all staff receive an annual appraisal.
- Ensure the process is clear on how patients or relatives could raise a concern or a complaint.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Medical care (including older people's care)	Good

Why have we given this rating?

We rated safety within the medical care services as good because:

- There was a positive approach to incident reporting with evidence of learning from within and external to the ward and hospital. Patients were informed by staff when things went wrong and given an apology.
- There were reliable systems in place to prevent and protect people from a healthcare associated infection and equipment was checked and maintained.
- There were sufficient nursing and medical staff to meet patient needs

The effectiveness of medical care was rated as good.

- Staff provided evidenced care and treatment. The endoscopy unit had received JAG accreditation and the renal unit had started to deliver haemodiafiltration to improve patient outcomes.
- There was a strong focus on multidisciplinary working.
- Staff had a good understanding of the mental capacity act and its application in practice.

However:

- Not all staff had received annual appraisals with one ward reporting only 8% of staff having had an appraisal in the previous twelve months.

We rated caring to be outstanding.

- Staff were seen to deliver care that was kind and compassionate and at times went the extra mile to care for both patients and relatives. Emotional and spiritual needs were met.
- Patients were highly positive about the care and attention they received.

We rated responsiveness as good.

- Services were planned to meet the needs of patients and visitors to the area.
- Discharge planning commenced on admission.
- Staff at the hospital went to great lengths to plan, deliver and coordinate care and services in a way that took into account patients' complex needs.

Summary of findings

However

- It was not clear how patients or relatives could raise a concern or a complaint.

We rated the medical care services to be well led.

- There were governance systems in place that ensured activity was monitored, risks were reflected on the risk register and findings were fed into the trustwide governance system.
- There was an open culture with a visible leadership where staff felt able to raise concerns
- There was innovative working and close engagement with the local community. Recruitment and retention strategies were in place.

West Cornwall Hospital

Detailed findings

Services we looked at
Medical care (including older people's care);

Detailed findings

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Background to West Cornwall Hospital

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in Cornwall. The trust is not a Foundation Trust and performance is monitored by the Trust Development Authority (TDA).

The trust serves a population of around 450,000 people, a figure that can be doubled by holidaymakers during the busiest times of the year.

Cornwall ranks 110th out of 326 local authorities for deprivation (with 1st being the most deprived).

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

Our inspection team

Our inspection team was led by:

Chair: Edward Baker, Deputy Chief Inspector of Hospitals South

Head of Hospital Inspections: Mary Cridge, Head of Hospitals Inspections, South West

The team included CQC inspectors and specialists including specialists in general medicine.

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Royal Cornwall Hospital NHS trust and the West Cornwall Hospital. These included the local commissioning groups, the Trust Development Agency, the local council, Healthwatch, the General Medical Council, the Nursing and Midwifery Council and the royal colleges.

We carried out an announced inspection on 14 January 2016. We held a drop in session for staff and talked to staff on an individual basis. We talked with patients and observed how they were being cared for. We talked with carers and family members, and reviewed patients' records of their care and treatment.

Detailed findings

Facts and data about West Cornwall Hospital

The West Cornwall Hospital provides medical inpatient care for older people split across two wards which are a mixture of six bedded bays and side rooms. There is a nine station nurse led Renal Unit, an endoscopy suite and provision for day case surgery, as well as diagnostic and therapy services and a wide range of outpatient clinics. The hospital has a 24-hour urgent care centre, which is run by the trust and is a type 3 doctor-led service.

Since its registration with the Care Quality Commission, West Cornwall Hospital has been inspected five times: in 2011, 2012, 2013, 2014 and 2015.

In the Friends and Family test for August 2014 to July 2015 the trust had good performance.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Notes

Medical care (including older people's care)

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

Information about the service

West Cornwall Hospital is one of three acute hospital locations run by Royal Cornwall Hospitals NHS Trust. It provides inpatient and day care treatments and surgery, as well as diagnostic and therapy services and a wide range of outpatient clinics. There is a nine station nurse led Renal Unit, an endoscopy suite and provision for day case surgery.

The hospital has a 24-hour urgent care centre, which is run by the trust and is a type 3 doctor-led service.

Summary of findings

We rated safety within the medical care services as good because:

- There was a positive approach to incident reporting with evidence of learning from within and external to the ward and hospital. Patients were informed by staff when things went wrong and given an apology.
- There were reliable systems in place to prevent and protect people from a healthcare associated infection and equipment was checked and maintained.
- There were sufficient nursing and medical staff to meet patient needs

The effectiveness of medical care was judged to be good.

- Staff provided evidenced care and treatment. The endoscopy unit had received JAG accreditation and the renal unit had started to deliver haemodiafiltration to improve patient outcomes.
- There was a strong focus on multidisciplinary working.
- Staff had a good understanding of the mental capacity act and its application in practice.

However,

Medical care (including older people's care)

- Not all staff had received annual appraisals with one ward reporting only 8% of staff having had an appraisal in the previous twelve months.

We rated caring to be outstanding.

- Staff were seen to deliver care that was kind and compassionate and at times went the extra mile to care for both patients and relatives. Emotional and spiritual needs were met.
- Patients were highly positive about the care and attention they received.

We judged the responsiveness domain as good.

- Services were planned to meet the needs of patients and visitors to the area.
- Discharge planning commenced on admission.
- Staff at the hospital went to great lengths to plan, deliver and coordinate care and services in a way that took into account patients' complex needs.

However

- It was not clear how patients or relatives could raise a concern or a complaint.

We judged the medical care services to be well led.

- There were governance systems in place that ensured activity was monitored, risks were reflected on the risk register and findings were fed into the trustwide governance system.
- There was an open culture with a visible leadership where staff felt able to raise concerns.
- There was innovative working and close engagement with the local community. Recruitment and retention strategies were in place.

Are medical care services safe?

Good

We rated safety within the medical care services as good.

- There was a positive approach to incident reporting with evidence of learning from within and external to the ward and hospital. Patients were informed by staff when things went wrong and given an apology.
- There were reliable systems in place to prevent and protect people from a healthcare associated infection and equipment was checked and maintained.
- There were sufficient nursing and medical staff to meet patient needs

Incidents

- The trust had an electronic incident reporting system which could be accessed by all staff to report incidents. Staff described feeling confident to raise concerns and record safety incidents. For example, staff told us they would record incidents such as a staffing shortage, or if a patient had a fall.
- Nurses told us patient falls and challenging patient behaviour accounted for the largest number of incidents. Since the last inspection staff had reported three serious incidents, all of which were patient falls.
- The matron in charge of the hospital reviewed all incidents reported. If the incident was not thought to be serious, investigation was delegated to the ward manager. Where the incident was felt to be serious, the matron undertook the investigation. Findings from all incidents were reviewed at the monthly governance meeting, attended by the ward sisters. Feedback was provided by them back to their ward areas.
- Learning from incidents were discussed at ward meetings every two months for which meeting minutes were recorded and disseminated among staff to ensure all had access to the learning.
- Staff shared examples of feedback they had received from incidents and how this led to a change in practice. For example, level three care was introduced for a patient who had fallen. Level three ensured a member of staff always kept the patient in their line of sight, in order to reduce the risk of the patient falling. The hospital linked with the trust wide falls group to ensure

learning was shared and to identify improvements in practice, for example falls pressure mats and gripping yellow socks which also acted as a visual alert to staff that the patient was at risk of a fall.
- Learning from serious incidents that occurred elsewhere in the trust was also shared, for example changes to checking processes after a serious incident within ophthalmology, and an alarm which sounded hourly to prompt staff to check all vascular access within the renal unit.
- Duty of Candour legislation has been in place since November 2014 and requires an organisation to disclose and investigate mistakes and offer an apology if the mistake results in a death, severe or moderate level of harm. We saw patients were informed by staff when things went wrong and given an apology.
- Senior nursing staff attended mortality and morbidity review meetings that took place every second month. Learning from these meetings was shared with nursing staff regularly at team meetings.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. These included the number of falls, pressure damage, infection control, venous thromboembolism (VTE) and incidents. Staff completed the safety thermometer monthly.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare associated infection. Side rooms were used for infection control purposes and staff liaised with infection control staff if there were concerns.
- We saw staff using personal, protective equipment and washing their hands before and after an episode of care.
- All areas were visibly clean. Equipment was seen to have stickers in place indicating it had been cleaned and was ready to be used on another patient.
- Cleaning services were provided by an independent company who met with the matron bi-monthly to discuss issues or concerns.

Environment and equipment

- There were systems in place to ensure equipment was checked and maintained. Electrical equipment seen had been safety checked. Staff (either daily or weekly as per trust policy) checked defibrillators and other resuscitation equipment regularly and completed checks were recorded.
- Staff had access to pressure relieving equipment such as mattresses and cushions for patient with pressure ulcers.
- The corridor leading to the endoscopy area was accessible to patients and relatives attending the hospital. The endoscopy decontamination room and storage room, containing endoscopes and decontamination fluids, opened onto this corridor. Both these rooms were unlocked which posed a risk to patients and members of the public. We raised this concern with a senior nurse at the time of the inspection.

Medicines

- Arrangements for the storage of medicines kept people safe. Staff stored medicines and controlled drugs safely in line with guidelines and best practice. Staff on the wards checked fridge temperatures daily and documented this correctly. Intravenous fluids were securely stored.
- A pharmacist visited the wards daily Monday – Friday to undertake medicines reconciliation and provide advice and support to staff. Out of hours the on call pharmacists at the Royal Cornwall Hospital provided pharmacy support. In the event of medicines being needed out of hours that were non stock, courier transport was arranged.

Records

- Records were securely stored in locked cabinets to ensure patient confidentiality. We reviewed sixteen sets of records. All were well maintained and contained care plans that were individualised and reviewed according to the patient's needs.
- Whilst most records were clear and contemporaneous, not all entries were signed and dated, however plans of care were clearly documented and easy to follow.

Safeguarding

- Staff were aware of how to raise safeguarding concerns. Staff in the renal unit described close working with the learning disability team.

Medical care (including older people's care)

- Staff had access to the trustwide safeguarding leads. In addition, the wards had identified dementia leads and link workers who were available to provide additional support and advice to staff.

Mandatory training

- 92% of staff at the hospital had undertaken the trust mandatory training, which included manual handling, safeguarding adults and basic life support.

Assessing and responding to patient risk

- Risk assessments were carried out for all patients whose notes were reviewed. Staff carried out falls assessments to identify patients at increased risk of a fall. Level three patients were those who staff needed to keep in their line of sight at all times and level four patients were those who staff needed to be within touching distance of at all times. We observed a HCA caring for patients in this way on the wards and senior nurses told us this helped reduce the risk of patients falling.
- Staff were able to assess and respond to patients whose health was quickly deteriorating. Staff used an early warning score to identify the deteriorating patient. Medical staff were present in the hospital at all times to review any concerns raised.
- Senior staff described the process for transferring critically ill patients as "very responsive." An escalation process was in place to link with the main hospital site when needed.
- Staff used the malnutrition universal screening tool (MUST) to establish patients' nutritional risk score. Records indicated patients with a high MUST score were weighed twice weekly.
- Staff assessed patients regularly for the risk of pressure ulcers. There was a tissue viability link that could be called upon to give expert advice when needed. A tissue viability nurse and nurse consultant based at The Royal Cornwall Hospital provided further support and guidance to staff. Nurses also liaised with the tissue viability nurse in the community.

Nursing staffing

- Planned staffing levels matched actual levels at a ratio of one nurse to eight patients. This was in line with national guidance. Many staff told us that staffing levels felt safe and that the skill mix was appropriate. If they felt unsafe with regards to staffing or skill mix, nurses felt able to flag this with ward managers.
- There was total of 3.6 whole time equivalent registered nurse vacancies and 1.3 health care assistant vacancies across both medical wards. The hospital took part in the trustwide recruitment drives, placed student nurses and also took newly qualified nurses who were supported with a preceptorship program. In addition they also recruited registered nurses who had undertaken a 'return to nursing' course. Turnover was described as low, with many staff we spoke with describing a long working history at the hospital. However, sickness was higher than the trust target of 3.75%, at 9% on medical 1 and 8% on medical 2.
- The hospital carried out an acuity review to assess staffing levels. This was last undertaken in November 2015 and had resulted in an increase in the funded establishment for healthcare assistants.
- Bank staff and agency staff were used, though a senior nurse commented that it had become increasingly difficult to access trained nurses. Some agency staff could be blocked booked or the hospital would use the same staff repeatedly to promote continuity. If a ward was short staffed at short notice, senior nursing staff said that this could be challenging as there was only one other ward they could 'borrow' staff from and as a result, the deficit was split between both wards.

Medical staffing

- There was a junior doctor present in the hospital at all times. In addition, a consultant was present five days per week and undertook daily ward rounds, reviewing all inpatients. During weekends and bank holidays, a GP from the urgent care centre could be asked to attend the wards to see patients when needed, in order to provide additional support.
- Medical staff on the wards took part in daily handovers as part of the multidisciplinary team meeting.

Major incident awareness and training

- Staff told us that they had a backup generator in the event of a power failure and they had fire wardens who were trained to use fire extinguishers, should they be needed.
- There was a trustwide major incident plan.

Are medical care services effective?

Medical care (including older people's care)

Good

The effectiveness of medical care was judged to be good.

- Staff provided evidenced care and treatment. The endoscopy unit had received JAG accreditation and the renal unit had started to deliver haemodiafiltration to improve patient outcomes.
- There was a strong focus on multidisciplinary working.
- Staff had a good understanding of the mental capacity act and its application in practice.

However,

- Not all staff had received annual appraisals, with one ward reporting only 8% of staff having had an appraisal in the previous twelve months.

Evidence-based care and treatment

- The renal unit had started to deliver haemodiafiltration from November 2015. This was proven to improve patient outcomes. The unit currently had seven stations capable of delivering this. There was a rolling program of replacement in place to bring this up to the required number of eleven.
- Staff had access to trustwide policies and procedures via the intranet.
- The renal unit had recently completed a hepatitis B clinical audit. As a result, patients whose immunity was low were offered a booster vaccination.
- The endoscopy unit had Joint Advisory Group (JAG) accreditation. This sets standards for individual endoscopists, sets standards for training in endoscopy, quality assures endoscopy units and quality assures endoscopy training courses. A repeat JAG inspection had occurred the day prior to our inspection.

Pain relief

- Patients were able to access pain relief as required. A variety of analgesia was stocked on the wards to ensure patient needs could be met.

Nutrition and hydration

- All patients had access to fluids that were in reach. Aware of the need for patients to remain hydrated, the wards were in the process of implementing 'drinking stations'. These were areas on the wards where patients who were prone to wander could access a seat and take a drink.
- Bi monthly meetings were held with a dietician employed by the meals provider. As a result, between meal snacks were available to patients, as well as 'finger food' to encourage patients who were unsettled and wandered, to eat.

Patient outcomes

- Patient outcomes formed part of the requirements for JAG accreditation. For patients in receipt of dialysis, outcomes were reported and reviewed within the overall renal services as well as feeding into the renal registrary.
- The average length of stay was higher than the England average for geriatric medicine (12.1days compared to 10) and general medicine (18.2 days compared to 6.4 days)
- The Standardised Relative Risk of Readmission was 98 (better than the England average of 100) to geriatric medicine but 162 (worse than the England average of 100) for general medicine.

Competent staff

- Staff within the renal unit undertook competency assessments which were reviewed at their annual appraisals. In addition staff were supported to attend additional training at degree level.
- Practitioner competency assessment formed part of the JAG accreditation assessment.
- Training records were held on the electronic staff record system which allowed senior staff an oversight of training compliance.
- Where possible, training took place either on line or on site at the West Cornwall Hospital. This made access to training easier for staff.
- Staff were offered supervision. Where supervision occurred, records were held within the individual's personal file. However there was no overall record kept to identify which staff had supervision and which did not.
- There was a significant difference in the number of staff who had received an appraisal in the previous year. Medical 1 reported compliance of 95%, however only 8% of staff on medical 2 had received an appraisal

within the last year. Senior staff told us the ward had been without a ward manager for a period of time. A new ward manager was now in post and a recovery plan was in place to ensure all staff received an appraisal.

Multidisciplinary working

- There were good multidisciplinary working practices in place.
- Staff from different teams and services were involved in assessing, planning and delivering peoples care and treatment, and coordinated care effectively. We saw effective multidisciplinary team working on the wards. We observed a multidisciplinary team meeting called a 'rapid round'. These meetings took place on both wards four days a week on a Monday and Wednesday through to Friday. On a Tuesday on one ward and a Wednesday on the other ward, staff held a more in depth MDT meeting. Medical staff, nurses, social services, Age UK, a discharge coordinator and therapists attended these meetings and discussions about each patients care and treatment included their discharge arrangements and package of care, ready for discharge.
- During the multidisciplinary team meeting the patient was assessed by all necessary staff, including those in different teams and services. For example an occupational therapist assessed the patient's mobility needs and nursing staff assessed the patient's physical health and any cognitive impairment.
- Nursing staff were knowledgeable about the patient's level of independence at home, simplified medicine regimens and ensured the patient had the right level of supervision and care in place when the patient went home. Staff wrote comprehensive discharge letters to the patient's GP and called the GP to discuss the patients discharge when necessary.
- The social care team that was based at The Royal Cornwall Hospital held a team meeting at the West Cornwall site on a Thursday which was attended by the discharge coordinator.
- Age UK workers formed part of the 'rapid round' multidisciplinary team meeting because they knew the journey and background of the patient and this aided discharge planning. The Age UK worker also supported patients in the community with the discharge process for example, they helped to organise shopping, ensured the patient was registered with a local GP and took them to the GP practice. This helped to improve the discharge process.
- Staff worked closely with Age UK and funding was recently secured for two representatives to work on the wards for 20 hours per week supporting patients and staff with the discharge process and initiatives such as the memory café. This role was due to start in January 2016 and staff had already completed an induction process with the hospital at the time of our inspection.
- The dementia liaison nurse assessed the patient's home situation through effective working with the patients' family and multidisciplinary teams inside and outside the hospital. For example, they held a discharge planning meeting and a best interest meeting if the patient lacked mental capacity, with the patient's family. The dementia liaison nurse coordinated care with the relevant community team to get the patient assessed for residential or nursing home care following these meetings. The family, medical and therapy teams were involved at all times to ensure the most appropriate package of care was in place.
- The dementia liaison nurse referred patients straight to the community psychiatric nurse if needed. Staff felt this ensured the patient could go home safely and reduced the risk of the patient being readmitted. Staff also accessed a welcome home scheme through Age UK where someone could go home with the patient and supported them with transitioning back into their home. The Age UK person formed part of the multidisciplinary team and they pick up referrals from the ward round that took place daily.
- Discharge planning started on the day of admission. The service was very well connected to the local community. They worked well with other agencies and were aware of the risks of long term admissions for the person. There was a focus on goals and independence for the patient, which was recognised by therapy staff who commented that therapy from nurses, took place 24 hours a day.
- A band five discharge nurse was available on both wards and staff rotated the nurse allocated to this role. In general, patients were discharged in the early afternoon as staff told us the care agency liked to go out to the patient's house first to ensure their home was a suitable environment for them to return to. This helped to reduce the risk of the patient being re-admitted.

Seven-day services

- Therapy and social care input was only available during the week and medical cover reduced at weekends.

Medical care (including older people's care)

- GPs from the urgent care service supported staff on the medical wards at weekends and during bank holidays.
- Out of hours pharmacy support was available from the Royal Cornwall Hospital.
- An acute GP clinic was held on the ward from 12-5pm seven days a week. GPs reviewed patients here which was felt to support admission avoidance.

Access to information

- Staff felt the information management systems in place on the wards supported them to deliver effective care and treatment. The electronic white board on both wards which all staff accessed had been in place for a number of years. These displayed detailed information relating to each patient such as, the patients' estimated discharge date, and clinically stable date, risk of falls, if they were living with dementia and the complexity of their discharge. The discharge process for each patient was flagged as simple or complex. This meant staff knew in advance the level of involvement of social care and others services that was required to enable an effective, safe and timely discharge.
- A dementia liaison nurse worked on the medical wards and accessed an electronic patient database which was used by the local mental health trust. They accessed information such as the patient's mental health risk factors and used this information to liaise between the hospital, GP practices and community care.
- The dementia liaison nurse attended ward rounds when a patient was admitted and shared relevant information about the patient during this process. For example, if a patient was under a safeguard they would investigate this and coordinate input from other services.
- In order to support the effective ongoing care and treatment for the patient in a timely way, staff worked closely with others teams and patients families. Staff told us how crucial it was to find out about the patients family situation, home life and community services used by the patient.
- Nurses filled in an electronic discharge form which was used to request support from social services and a local early intervention team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their role with regards Deprivation of Liberties. We reviewed the records of a patient who was subject to a deprivation of liberties order. This was well documented and contained information about best interests. When deprivation of liberty safeguards were approaching their expiry date someone from the DoLS team within the local authority came in regularly to review the DoLS and reassessed patients' mental capacity.
- Treatment escalation plans were completed correctly and included family involvement in decision making where the patient lacked capacity. Staff also described the process for best interest meetings and gave examples of when these would be held. This indicated a good knowledge and understanding of the mental capacity act and the capacity of patients to consent to treatment.

Are medical care services caring?

Outstanding ☆

We rated caring to be outstanding.

- Staff were seen to deliver care that was kind and compassionate and at times went the extra mile to care for both patients and relatives. Emotional and spiritual needs were met.
- Patients were highly positive about the care and attention they received.

Compassionate care

- We observed care that was delivered with compassion and dignity. Within bays, curtains were drawn to protect patients' privacy and dignity and staff were seen to knock on doors before entering side rooms.
- Staff were seen to be responding well to patient's requests and all patients we spoke with reported that the nurses promptly managed their individual personal needs. While moving a patient who wanted to sit in his chair, we observed staff being polite, kind and patient, explaining each step of what they were doing.
- Staff described how they encouraged patients to socialise and to enjoy their hospital stay. For example, at Christmas, staff organised for tables to be brought out into the ward's main thoroughfare. Staff of all grades served Christmas lunch to patients who were assisted in order to dine at the table, where they played games and were entertained by staff.
- The wards took part in the Friends and Family Test. The Friends and Family Test (FFT) is a feedback tool that

supports people who use NHS services to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. Whilst response rates were low across the wards, at only 27%, within the year 2015, 96-100% of patients said they would recommend the service. Thank you cards from patients and families were displayed on the ward.

- Patients also described compassionate care from staff. One patient told us "they are very good. They bring you back to the real world when you are first dialysed with their friendliness and chit chat."
- Staff were also seen to be compassionate towards the needs of visitors and relatives. We observed an elderly patient being visited by their relative who staff recognised was also frail. As the relative was determined not to leave the patient's side, ward staff ensured they had a suitable chair to rest in, received meals and that they had taken their medicine correctly.

Understanding and involvement of patients and those close to them

- We observed staff going the extra mile by providing a 'memory café' in the day room on a weekly basis. Patients and family members could attend for free and were invited to engage in singing, quizzes and games to help engage people living with dementia. Patients received tea and homemade cakes made by the nurses, along with prizes. During our inspection we observed a memory café and saw that this was ran by two nurses, two healthcare assistants and a volunteer. Seven patients and two family members attended. One patient reported that they, "love going to the memory café". It was clear that the nurses were highly motivated as the nurses attended in their own time to ensure the success of the memory café. A volunteer informed us that this was a regular occurrence. Staff also described occasions where patients without dementia were encouraged to attend with their relatives who themselves were living with dementia. This meant their relative could be engaged and felt comfortable and at ease when visiting.
- All of the patients we spoke with were positive about their care and told us they felt involved in their care and that information had been explained in a meaningful way. A patient who had difficulties communicating expressed that the staff gave them the time to communicate and involved him in decision making. Another patient said "They always tell you what they are doing, so you know what's what."
- We spoke with three family members who said they felt included in the care of their relative and were kept informed of any changes or developments.
- We observed patients being given a choice at meal times. We witnessed a member of staff engaging with a patient who lacked the capacity to feed themselves. The nurse interacted with them in a compassionate way by assisting them at their own pace, talking to them and only giving them as much food as they wanted.
- Learning from an 'elder care senior nurses meeting' was shared. As a result, staff had installed a comfort box with tea and coffee and a flask on wards or in side rooms where relatives were with patients who were very ill or receiving end-of-life care. The meant they did not have to disturb staff or leave the patients' side in order to request refreshments.
- Staff described occasions when they arranged for pets to be brought onto the ward to visit patients. This had included some patients who were receiving end-of-life and was felt to have provided an enormous support to the patient.

Emotional support

- We observed and heard staff providing emotional support to a patient who had become upset. Patients were spoken to calmly, supportively and took time to ensure the patients wellbeing.
- Staff also described addressing the spiritual and emotional needs of patients. For example, an elderly, terminal patient's close relative recently passed away. They were too ill to leave the hospital to attend the funeral. The chaplain and ward staff organised for a service to take place for the patient and their wider family who attended the service in the ward's day room.

Are medical care services responsive?

Good

We judged the responsiveness domain as good.

- Services were planned to meet the needs of patients and visitors to the area.

- Discharge planning commenced on admission.
- Staff at the hospital went to great lengths to plan, deliver and coordinate care and services in a way that took into account patients' complex needs.

However

- It was not clear how patients or relatives could raise a concern or a complaint.

Service planning and delivery to meet the needs of local people

- Though at full capacity, the renal unit had two sessions available for holiday makers. Staff described working closely with 'home units' to ensure patients in need of dialysis were able to visit the area on holiday. They also described the reciprocal arrangements in place to support their own patients in accessing holidays away from the area.
- Where possible, patients who lived nearby were transferred into the hospital. This meant they were nearer to friends and family and felt 'closer to home'.
- Families and visitors used a day room when spending time with patients. There was a garden just off the day room which both patients and relatives accessed.
- Staff spoke of a recent focus on getting equipment that could be used to deliver single-handed care. This meant that only one carer would be needed to support the patient's movement. This meant patients were more likely to be discharged if they only required a single-handed package of care. The equipment was in place on the wards in order that staff and patients could get used to it. Additional manual handling training had been instigated to support this.

Access and flow

- The majority of patients at West Cornwall Hospital were admitted following transfer from The Royal Cornwall Hospital. Occasionally patients were admitted via the urgent care department or directly from local GP practices. It was rare for there to be empty beds on either ward.
- Discharge planning commenced on arrival and each work had a discharge nurse in place four days per week. Their role was to 'chase' processes and ensure discharges occurred in as timely a manor as possible.
- Patients were given an estimated discharge date which was revised after every multidisciplinary team meeting and amended by the ward clerk onto the electronic screen. Pharmacy staff came on to the wards regularly and staff reported medicines to take home were ready in time for the patients' discharge, as medicine requests were flagged early in the day following the 'rapid round'.
- However, many patients remained in the hospital beyond the date at which they were deemed medically fit for discharge. At the time of the inspection there were 17 out of the 24 patients on medical ward one who were medically ready for discharge. These patients were awaiting a suitable package of care in the community. Staff reported the primary reason for delays to discharge as a lack of availability of packages of care in the community often due to the rurality of where the patient lived. For example a conversation took place during the morning of the inspection regarding a patient staff could not discharge, because they required a four times a day package of care. Staff did their best to try and coordinate care effectively in order to manage the situation, even attempting creative methods to support the delivery of the care needs. This included enquiring about the feasibility of staff from a local nursing home delivering some of the patients care, in order to facilitate their discharge.
- Staff also informed us of another incident with a patient who was on the ward in December 2015. His family were desperate to get him home for Christmas but they were unable to get a package of care in the community and so the patient remained in the hospital. Some patients had waited more than two months to be discharged and some had waited so long that they had passed away and had been unable to die in their desired place of death.

Meeting people's individual needs

- Staff at the hospital went to great lengths to plan, deliver and coordinate care and services in a way that took into account patients' complex needs. This was especially evident in the way the hospital and its staff cared for patients living with dementia. The hospital had undergone a dementia mapping exercise two years ago with Cornwall Council. This had shown a poor level of care for the patients living with dementia. As a result, staff at the hospital looked at the type of care in the community available for patients living with dementia, and tried to mirror this. They networked with other organisations who ran memory cafés in the community and then replicated it in the hospital.

Medical care (including older people's care)

- The hospital worked collaboratively with outside agencies to ensure patient needs were met. Two posts had recently been created for 22.5 hours a week on each ward. The staff had just been recruited and were employed by Age UK for a one year pilot with the potential to continue after this. Their primary remit was in supporting the care of patients living with dementia though daily ward based activities.
- The trust undertook a 'spring to green' initiative in 2015 which brought activities onto the ward and at the bedside, for patients living with dementia. Staff commented that the interaction between patients and volunteers had helped patients to feel calmer, and to sleep and eat better. The overall aim was to improve health status making discharge more likely.
- Wards were dementia friendly with different coloured doors and door handles. They had toilets with both signs and writing, and floors were non-slip and non-reflective. Chairs were placed in the corridor of the ward along with drinks to provide a place of rest and rehydration to patients that wandered. In addition, staff were working with the meals provider to identify crockery that through colour, encouraged appetite.
- A dementia liaison nurse gave advice to staff, families and carers and each ward had a dementia link nurse. Part of the role was to provide additional activities for the patient and to ensure the patient's privacy and dignity during end of life care.
- To support the needs of patients with a learning disability, staff accessed the learning disability team which was available from Monday to Friday from 8am to 5pm. A member of the learning disability team came to see the patient or spoke to staff on the phone to offer support.
- Staff accessed translation services through the urgent care department or could call a translation service phone number. Staff found this was no longer available on the wall on ward one, however staff felt they would be able to access translation service in order to support patients who did not speak English, should the need to.
- Patients were able to access a variety of different snacks and drinks throughout the day. Snacks were available during the morning coffee and tea rounds and patients could choose cake, biscuits, a banana sandwich, yoghurt or ice cream. There was a patient fridge in the day room. Staff were able to accommodate requests for food at any time of the day. One staff member told us if a patient requested food at any time of the day, staff could go and make them something, such as a jam sandwich and felt that this often helps patients to sleep better.
- Patients ordered their lunch just after their breakfast and ordered their supper, after they had ordered their lunch. Staff felt this made it more likely for patients to know what they wanted and would eat better as a result. Two patients we spoke with reported that staff were happy to provide them with a different meal if they did not like anything on the menu. Food was also available to suit different diets and in different formats such as puréed, if needed.
- Some staff felt there was little access to psychiatric services for patients at the hospital. They were able to access some input from community psychiatric nurses but resources were felt to be stretched

Learning from complaints and concerns

- We asked four patients if they were aware of the procedure to make a complaint. None of those asked knew how to do this. There was a lack of information displayed about the Patient Advice and Liaison Service (PALS). We only saw one information leaflet area with PALS leaflets, which were not clearly visible to patients or visitors. This meant patients or relatives could have difficulty in finding out how to raise their concerns.

Are medical care services well-led?

Good

We judged the medical care services to be well led.

- There were governance systems in place that ensured activity was monitored, risks were reflected on the risk register and findings were fed into the trustwide governance system.
- There was an open culture with a visible leadership where staff felt able to raise concerns.
- There was innovative working and close engagement with the local community. Recruitment and retention strategies were in place.

Vision and strategy for this service

Medical care (including older people's care)

- The trusts visions and values were communicated through team talks on a monthly basis and staff received a 'Friday flyer' by email, as well as daily updates and trust wide emails.
- Data was displayed on screensavers on the electronic white board which demonstrated the current safety strategy. For example, there was a focus on maintaining patient confidentiality through effective storage and management of patient records. Staff told us that this had been a focus at the trust for some time and spoke competently about the rationale behind this focus.

Governance, risk management and quality measurement

- Governance systems were in place. Governance meetings took place monthly for the whole hospital, in which risks and incidents were discussed and learning shared. In addition the hospital performance assurance framework was reviewed which identified concerns and quality performance ratings. These meetings fed into the overall trust medical division governance system which fed up to the board.
- The risk register reflected the current risks described by staff. These were the risk of patient harm as a result of slips, trips and falls, violence and aggression (within the urgent care centre) and staffing concerns. Risks were monitored at the governance meeting and actions were put in place to mitigate. For example, the hospital took part in trust wide recruitment drives, had supported return to practice nurses and supported newly qualified nurses through a preceptorship program.

Leadership of service

- The matron was viewed by staff as the link regarding information flowing between The Royal Cornwall Hospital and West Cornwall Hospital. The matron attended meetings and relayed information to staff. Feedback to therapies staff occurred following monthly trust wide meetings.
- Trainee medical staff praised the leadership within the hospital commenting they felt very well supported. Supported with their training and development.
- Nursing leadership was felt to be strong and supportive. Staff felt supported to raise concerns at any time. Domestic and catering staff also expressed feeling supported by the managers, despite not being employed by the trust. Though not formal employees they described feeling part of the hospital team.

Culture within the service

- A number of staff had worked at the hospital for a long time and spoke about the familial atmosphere and culture within the organisation. Staff were very proud of the strong relationship they had with the local community and these close links with the community were evident.
- Staff were very proud of their hospital. A culture of teamwork was clearly evident and staff said they were personally very close and caring towards each other. This was reiterated by volunteers and organisations who worked with the hospital.
- Staff were open about issues the hospital had faced, such as staffing issues, recruitment and sickness. They were also keen to express that they felt the quality of care was excellent. Staff said they had been well supported by leadership to address issues as they arose.
- There was a culture of learning at the hospital. Staff who had meetings at or who visited the Royal Cornwall Hospital saw this as an opportunity for learning to be shared between sites. There was an open attitude between hospitals that staff felt was not there a number of years ago. They commented that now they felt more like an extension of the Royal Cornwall Hospital rather than two separate hospitals.

Public engagement

- The League of friends had secured £750,000 for a new outpatients department four years ago but the decision to take this forward had been delayed repeatedly due to changes in senior management. A decision was due to be made on the future of this shortly. Both medical wards had also received significant funding from the league of friends. This had provided refurbishment to the ward areas.
- There was a clear level of engagement with the local community and volunteers from the local community were involved in a number of initiatives within the hospital, such as discharge support by Age UK and the memory café.

Staff engagement

- The trust held a 12 days of Christmas initiative where members of staff could bid for money to spend on

something that improved the service in which they worked. The outpatients department in West Cornwall Hospital had received funding to purchase new books and magazines for the waiting rooms.

- Staff spoke highly about an initiative that was instigated by the previous chief executive, called 'listening into action'. This focused on consulting with staff to understand "what was making life difficult for staff in the trust". It had used ideas generated by staff to address these. Staff informed us the trust had communicated widely and frequently about this, but felt that some of the ideas employed were diluted versions of the suggestion and as such had not been as effective as they had envisaged.
- A number of staff felt they had little access to the board due to the lack of continuity within the Royal Cornwall Hospital Trust's senior leadership team.
- Staff expressed concerns that the patient transport company employed staff that were at times, not adequately trained. For example, they were unable to use basic turning equipment which enable them to get patients out of vehicle and into their home. As a result, on occasions staff were sent home with the patient in order to overcome this. Staff felt that the trust had not always engaged with them to seek feedback when tendering for services such as this.
- The hospital held a 'working lunch' every six weeks. This was an open forum held in a ward day room which allowed staff to attend, eat their lunch and receive updates or raise concerns.

Innovation, improvement and sustainability

- The trust trialled initiatives that it hoped would improve patient flow at the hospital. For example, it commissioned an early supported discharge team to get patients discharged earlier. Short term reablement care was provided over five or six weeks. The pilot had recently been approved for the orthopaedic frail team.
- The hospital worked closely with Age UK to provide additional services to patients on discharge. This ensured their home was ready for them when they returned. Their presence within the hospital also supported the care of patients living with dementia.
- Whilst recognising recruitment was an ongoing issue, the hospital had developed a wide range of recruitment strategies such as return to nursing, preceptorship to allow newly qualified nurses to work at the hospital and the placement of student nurses during their training. It also had succession planning in place for band six nurses and rotated staff within the hospital to broaden their skills.

Outstanding practice and areas for improvement

Outstanding practice

- Staff went the extra mile by providing a 'memory café' in the day room on a weekly basis. Patients and family members could attend for free and were invited to engage in singing, quizzes and games to help engage people living with dementia. Patients received tea and homemade cakes made by the nurses, along with prizes.
- The hospital worked closely with Age UK to provide additional services to patients on discharge. This ensured their home was ready for them when they returned. Their presence within the hospital also supported the care of patients living with dementia.

Areas for improvement

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure the decontamination room and storage room used by the endoscopy service is kept secure at all times.
- Ensure there is a system to monitor staff accessing clinical supervision.
- Ensure all staff receive an annual appraisal.
- Ensure the process is clear on how patients or relatives could raise a concern or a complaint.