

Royal Cornwall Hospitals NHS Trust

Quality Report

Treliske
Priory Road
Truro
Cornwall
TR13LJ
Tel: 01872250000
Website: www.rcht.nhs.uk

Date of inspection visit: 3-5 and 15 June 2015
Date of publication: 23/09/2015

This report describes our judgement of the quality of care at this trust. 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 trust

Requires improvement



Are services at this trust safe?

Inadequate



Are services at this trust responsive?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Royal Cornwall Hospitals NHS Trust to check if changes had been made in specific areas where we found breaches of regulations during our comprehensive inspection in January 2014. The inspection was carried out between 3 and 5 June and on 15 June 2015.

We inspected Royal Cornwall Hospital in Truro and West Cornwall Hospital in Penzance in this inspection. We did not inspect St Michael's Hospital in Hayle, St Austell Hospital - Penrice Birthing Unit or the Royal Cornwall Hospitals NHS Trust Headquarters.

We inspected Royal Cornwall Hospital:

- Urgent and emergency care
- Medical services
- Surgical services
- Critical Care

We also inspected the following at West Cornwall Hospital:

- Medical services

Overall we judged the Trust as requires improvement in the areas inspected as part of this focused inspection. Improvements were required in safety which was judged as inadequate and responsiveness as requiring improvement at Royal Cornwall Hospital. West Cornwall hospital was judged as good.

Our key findings were as follows:

- The Emergency Department was struggling to manage flow and crowding. This was exacerbated when medically expected patients were also streamed through the department. These were patients who had been referred by other healthcare professionals (for example, their GP) who would normally be admitted direct to a ward. The Trust was consistently failing to achieve key performance targets and patients were experiencing long delays from their time of arrival to a decision to be admitted or discharged. This requires a system wide response if this is to be improved.
- We had concerns around nursing staffing levels in the main and children's emergency department, which were placing patients at high risk of poor care. The existing establishment had been reviewed and found

to be insufficient and unsafe; however, numbers had not been increased to the required 14 on days and 11 on nights. Staffing levels had not been increased when the department expanded from nine to 23 major illness bays.

- In the main emergency department on occasions there was insufficient staff to provide a safe environment for patients. In the children's emergency area there was one nurse on duty, who was not always a trained children's nurse.
- The levels of sufficiently skilled staff, in the high care bay on Wellington ward (where patients who may require higher levels of care or requiring non-invasive ventilation were co-horted) were of concern where we observed occasions when healthcare assistants and assistant practitioners were left for periods of time caring for patients requiring high levels of care.
- The trust now used lockable cabinets to store patient care plans and medical records. This had been done in response to our previous compliance action. All wards but one were using the lockable storage appropriately and maintaining patient confidentiality.
- We saw good examples of staff responding to patients who lacked capacity to ensure they were safe.
- In some areas patient records were not always complete and did not inform staff of the care and treatment needed to ensure patient safety
- All areas of the hospital we visited were noted to be visibly clean.
- There were some places where limited storage for equipment resulted in some being stored in corridors.
- The Trust had experienced high numbers of emergency admissions throughout the six months before our inspection. This resulted in planned surgery being cancelled for a significant number of patients as medical patients were admitted to surgical wards.
- The Stroke Unit (Phoenix ward) was not responsive in its care for patients diagnosed with a new stroke. Delays in discharging patients meant patients were being managed on other wards, affecting their access to therapeutic stroke care.
- There had been investment in the critical care outreach team to respond to the needs of patients in the wider hospital.

Summary of findings

We saw several areas of outstanding practice including:

- An example of a patient who had a form of dementia who needed surgery. His wife visited the ward prior to him; he then visited with his wife. When he was admitted to the ward his wife was able to stay with him, accompany him to the operating theatre and was waiting for him on the ward on his return from recovery. His wife was able to stay overnight with him and help care for him during his stay in hospital. The staff thought the experience had lessened his length of stay in hospital. His wife has been asked to write about their experience and be part of a film talking about their experience which will be used to help train staff in the future.
- There were patient ambassadors who carried out 'point of care observations'. They observed patients to understand how day to day routines on wards and interactions they have with staff impacted on a patient wellbeing. The outcomes were shared with staff and formed part of future staff learning and development plans.
- We spoke with the theatre educator who told us about the "bite size" learning that she had implemented that covered core skills for staff of all grades. The sessions were offered within the work environment, on a rolling programme and had received good feedback. She said when staff were busy clinical teaching "goes by the way" but staff were able to attend short relevant sessions.

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

Importantly, the trust must ensure:

- Adequate nursing staffing are available and deployed in the emergency department to ensure people's care and treatment needs are met at all times.
- Sufficient numbers of suitably qualified staff are deployed at all times in the children's emergency department.
- All records in the emergency department are accurate, complete and contemporaneous.
- Equipment in the emergency department's resuscitation area is readily available.
- All electrical sockets in the children's emergency department are safe or out of reach.

- Action is taken to tackle ongoing performance issues in the emergency department, including flow and escalation.
- The emergency department is responsive at times of high patient attendance to mitigate the harmful effects of crowding – for example, through a structured and responsive management approach and control of the shop floor.
- Ensure the Stroke Unit (Phoenix ward) is responsive in its care for patients diagnosed with a new stroke. Caring for patients on other wards must not affect their access to therapeutic stroke care.
- Systems are consistently managed to identify the extent of outlying patients and ensure easy access for staff to appropriate consultant cover.
- Use of Cardiology unit beds for acute medical admissions does not adversely affect planned cardiology procedure admissions.
- Discharge planning arrangements are not responsive. Processes varied and the resulting delays in discharges impacted on planned admissions and flow through the emergency department due to lack of bed availability.
- Delays for patients with planned admissions to the critical care unit do not impact on patient outcomes.
- Reduce the number of patients who have their surgery cancelled and where this is unavoidable ensure that another date is booked and honoured within 28 days of the cancellation.
- Ensure that patient records are up to date and completed in full to ensure that all staff caring for the patients have access to all relevant details regarding on-going care at West Cornwall Hospital.

Professor Sir Mike Richards

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Background to Royal Cornwall Hospitals NHS Trust

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.

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

Our inspection team

Our inspection team was led by:

Chair: Jonathan Fielden, Medical Director, University College London Hospitals

Head of Hospital Inspections: Tracey Halladay, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant in emergency medicine, consultant in medicine, an emergency department nurse, a critical care nurse, and a medical nurse.

How we carried out this inspection

This was an unannounced focused inspection to review the areas of concern in relation to whether services were Safe and Responsive that were found when we carried out a comprehensive inspection of the Trust in January 2014.

The findings of our previous inspection in January 2014 were:

Safe- We found the services at the trust were safe however some improvements were required. Some patient notes were not accurate or complete, which could mean that there was not appropriate information

available to plan care or judge if a patient's condition was improving or deteriorating. Staffing levels had increased and while recruitment continues, bank and agency staff are employed to deal with shortages. Despite this, the staff working in medical and surgical wards at Royal Cornwall hospital felt under pressure at times. This had been recognised and the trust was continuing to actively recruit staff.

Responsive- The trust planned to provide services to meet the needs of the people they served. Royal Cornwall and West Cornwall Hospitals were very busy, with around 95% of available beds in use, while St Michael's Hospital

had less than 50% of beds in use. At Royal Cornwall Hospital, the high occupancy level, particularly in medical and surgical beds, was having an impact on the quality of care, and on the trust's ability to be responsive to people's needs. The lack of beds in parts of the hospital caused delays in the A&E department. Some surgical procedures were cancelled, and responsive care was complicated by medical patients being admitted to surgical wards due to shortages of beds on medical wards.

Patients were sometimes also delayed in their discharge into community care, because this was not being arranged in good time with, and by, other providers. The hospital was cancelling too many operations, and in some circumstances, there were inadequate facilities to consult with patients, which was causing further delays. The improvements required to ease the pressure on the trust needed to involve partners in the wider community to help manage the impact of the increasing number of people seeking treatment and the delays in people leaving the hospital.

At the most recent inspection we reviewed the following core services and domains at Royal Cornwall Hospital:

Summary of findings

- Urgent and emergency care – Safe and Responsive
- Medical services – Safe and Responsive
- Surgical services – Responsive
- Critical Care – Responsive

We also inspected the following at West Cornwall Hospital:

- Medical services – Safe

Before the inspection we gathered information from other stakeholders, including the Clinical Commissioning Group, the Trust Development Authority and Healthwatch Cornwall. As the inspection was unannounced, we did not hold a public listening event before the inspection.

We visited Royal Cornwall Hospital on 3, 4, and 5 June and West Cornwall Hospital on 3, and 4 June 2015.

We carried out further unannounced visits at Royal Cornwall Hospital on 15 June 2015.

We spoke with a range of staff including doctors, nurses, healthcare assistants, student nurses, and the chief executive, director of nursing and other members of the Trust board. We also spoke to patients and relatives.

What people who use the trust's services say

The Ambulatory Care Unit had been opened to relieve the pressure of patient demand from the medical assessment unit and emergency department. It took mainly patients who would be discharged within a few hours and did not require admission to a ward. We spoke with two patients who had been seen quickly and were very happy with the care they had received. They asked to be quoted saying "Impressed, impressed, impressed!"

Patients we spoke with on a variety of wards were complimentary about the care provided. They told us "the staff are great" and "staff are really good but run off their feet". Patients told us they felt the standard of care was very good. They also voiced that they were aware people were waiting for their beds and staff were very busy.

Facts and data about this trust

The Royal Cornwall Hospitals NHS Trust is the principal provider of acute care services in the county of Cornwall. There are 750 beds at three sites: Royal Cornwall Hospital in Truro, St Michaels Hospital in Hayle and West Cornwall Hospital in Penzance.

The Trust employs approximately 5,000 staff and has a budget of around £330 million.

In the year 2013-14 there were 105,122 inpatient admissions and 498,324 outpatient attendances. There were over 78,000 attendance at Accident and Emergency in the same period 2014-15.

In the 2014 inpatient survey responses were received from 414 patients at Royal Cornwall Hospitals NHS Trust. The trust scored about the same as others in A&E for being given enough information on their condition and treatment and for being given enough privacy when being examined or treated in A&E.


Patients feeling that they waited the right amount of time on the waiting list to be admitted for procedures scored 7.4 out of 10 which was worse than other trusts. Patients scored the trust as 8.9 out of 10 for not having their admission date changed by the hospital which was about the same as other hospitals scored for this question.

In the 2014 A&E survey the trust scored better than average for patients not having to wait too long before being examined by a doctor or nurse. They also scored about the same as other trusts for feeling reassured by staff if distressed while in A&E and for not having a long wait to receive pain relief if requested.

In the NHS staff survey 2014, 75% of staff responded that they were satisfied or very satisfied with support they get from work colleagues. 79% felt that their role makes a difference to patients and 59% agreed or strongly agreed that they would recommend the organisation as a place to work.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Overall, for the three services we inspected for the safe domain, we rated the safety of services as inadequate. The team made judgments about three services. Of those, one was judged as good and two as inadequate.</p> <p>The ratings of inadequate related to Royal Cornwall Hospital where we had concerns around nursing staffing levels in both the main and children's emergency departments, which were placing patients at high risk of poor care. The existing staffing establishment had been reviewed and found to be insufficient and unsafe; however, numbers had not been increased to the required 14 staff on duty for a day shift and 11 on night shift. Staffing levels had not been significantly increased when the department expanded from nine to 23 major illness bays. There was not enough appropriately skilled and experienced staff at all times in the main and children's emergency department and in the Wellington Higher Care Bay. We have taken enforcement action at Royal Cornwall hospital to ensure the trust takes immediate steps to address these areas of concern.</p> <p>Duty of Candour</p> <ul style="list-style-type: none">• The term Duty of Candour was not always understood by staff from the title but staff clearly understood their responsibilities to be open and transparent when things went wrong. Many described an open and honest culture.• We were told that senior staff had received some training around Duty of Candour and the incident reporting system had a place to indicate where it was applicable. <p>Safeguarding</p> <ul style="list-style-type: none">• All staff we spoke with were aware of safeguarding responsibilities and how to report any safeguarding concerns, and felt confident their concerns would be taken seriously.• We saw the emergency department had systems in place to identify safeguarding concerns. Staff were supported by dedicated link nurses for patients who were at risk of abuse. This included specific domestic violence link nurses. These link nurses were available to assist with patients in the department if required. They attended multi-agency meetings, ensuring a	<p>Inadequate </p>

Summary of findings

linked approach to the relevant services (for example, police and local safeguarding teams) and ensured the department was kept up to date with any developments from these meeting.

- There was a clear safeguarding process and checklist for children attending the emergency department and staff were knowledgeable about how this worked.

Incidents

- Staff in all areas were aware of the incident reporting process and explained that they were encouraged to report incidents. They received feedback from any investigation or action taken as a result. A wider cascade of information was also provided from other areas through the safety team briefs and newsletters, which identified themes and trends to be addressed.
- Root cause analysis was routine in relation to incidents and findings were shared, with action plans being put in place to prevent recurrence.
- However, at times it was said that near misses might be under-reported due to them being 'normal occurrences' or due to having insufficient time to complete an incident report. In particular, staff shortages impacting on the emergency department would not always be reported because these were considered to be 'the norm'.
- As a result of the tissues viability team reviewing all pressure ulcers, recent changes had been made to implement a skin bundle, which was a recording system to enable staff to follow a plan of care for treatment. Learning from tissue viability audits was cascaded throughout the hospital.

Records

- During our previous inspection concerns about the confidential storage of records in ward areas had been observed. The trust now used lockable cabinets to store patient care plans and medical records. This meant they had responded to the previous compliance action. All the wards, apart from one, were using the lockable storage appropriately and maintaining patient confidentiality. However, records storage on Wellington ward did not ensure privacy and confidentiality as some records were held in plastic files through which patient details in records could be seen. These records included personal details of patients, including name, date of birth and prescription for blood products. This method of storage did not protect patient confidentiality.

Summary of findings

- A number of records were reviewed in the areas visited and our findings were mixed. In some cases assessments were not documented, nurses' signatures were not present and patient observations were not recorded.
- As part of the actions put in place since our inspection in January 2014, weekly peer reviewing of notes had taken place on a selection of medical wards (Wellington and Roskear ward, the Coronary Care Unit and the Cardiac Investigations Unit). Findings of the audits in these areas were discussed at team meetings and in newsletters circulated by their departments. This was part of a pilot of audit and did not yet occur elsewhere in the hospital.
- At West Cornwall Hospital patient confidentiality was maintained by using secure storage systems for records. Observational records were completed; however, there were occasions when the records were incomplete, with care plans missing or assessments not completed within the advised timeframe. A regular programme for auditing records was in place.

Staffing

- There were staff shortages and a lack of staff with appropriate skills and experience in some areas, such as the children's emergency department and Wellington ward Higher Care bay.
- In the children's emergency department there were insufficient registered sick children's nurses to ensure one was available on each shift. We noted several shifts where adult trained registered nurses were working without the support of a registered sick children's nurse, which might mean children did not receive care from staff trained to deal with them in a timely way.
- The main emergency department was not supported with sufficient staff at all times. This resulted in occasions where areas of the department were staffed by one trained nurse and a healthcare assistant for up to nine patients, which impacted on patients with delays in them receiving pain relief and other treatment.
- The lack of full staffing complement in the emergency department had been recognised by the department but no plan to increase staffing based on the results of staffing assessment tools had been agreed. Therefore the department continued to be dependent on bank and agency staff, which often left shifts unfilled, adding pressure to staff on a shift.
- There were gaps in medical staffing in the emergency department but while additional funding had been agreed recruitment and attracting applicants was challenging.

Summary of findings

- Staffing levels on the Higher Care bay on Wellington ward were not always sufficient to provide the skills and experience patients required. We observed that agreed staffing levels were not achieved at all times and arrangements for covering staff breaks were not robust. This placed patients at risk.
- The trust monitored staffing vacancies across the hospitals reporting on 1 July 2015 there were 621 staff whole time equivalent staff in post against an establishment of 731 whole time equivalents. Taking into account the number of staff in the recruitment process (75) this still left a deficit of 50 posts. Some wards including the Escalation ward were reliant on regular bank and agency staff to ensure sufficient resources were deployed. The trust mitigated this through use of regular bank and agency staff and ensuring that those staff had induction and orientation.
- Staffing numbers were recorded on the divisional risk registers which were discussed in relation to staffing at the Nursing and midwifery workforce meeting in April 2015. Reasons for difficulty in maintaining agreed staffing levels were recorded as being attributed to high sickness, impact of 12.5 hour shifts, staff retention and matching demand to capacity. A three month plan to address these key issues was to be developed.

Infection control

- In many of the wards we visited staff were observed to use antibacterial hand gel between patients. However, during a ten minute observation at the main entrance to Royal Cornwall Hospital six people leaving the hospital used the hand gel provided and 87 did not.
- We saw that the areas of the hospital we visited appeared clean and staff were cleaning.

Are services at this trust responsive?

Overall, we rated the responsiveness of services we inspected as requiring improvement. For detailed information please refer to the individual reports for Royal Cornwall Hospital and West Cornwall Hospital.

The team made judgments about four services. Of those, three were rated as requires improvement and one as inadequate. The rating of inadequate related to Royal Cornwall Hospital.

There were significant issues with flow of patients into, through and out of the hospital that impacted on the emergency department being able to ensure patients were admitted to the correct ward and speciality.

Requires improvement



Summary of findings

Patients booked for elective surgery who required a bed after their operation were regularly having their appointments cancelled. This was due to medical patients having to be admitted to surgical wards because the medical wards were full, often with patients fit for discharge but waiting for beds in other care settings or packages of care to be set up at home.

Service planning and delivery to meet the needs of local people

- The Ambulatory Care Unit had been opened to relieve the pressure of patient demand from the MAU and ED departments and took mainly patients who would be discharged within a few hours and not require admission to a ward.
- The trust was reviewing the use of operating theatres at St Michael's Hospital in Hayle to ensure that it was being used to maximum effect as there was capacity to provide more inpatient surgery than was currently being delivered. Initiatives to increase some surgical procedures could help to ease the flow at the Royal Cornwall Hospital and mean some patients could have their elective surgery nearer to home.
- There was a plan for the orthopaedic surgery teams had extended their operating day in order to carry out more elective orthopaedic operations and reduce the number of cancellations. This was a three-month pilot due to commence in July 2015, at the end of which the activity would be measured to identify if a reduction in cancelled operations had taken place.

Meeting people's individual needs

- There were good systems across the trust to support patients with learning disabilities. Patients were highlighted on computer systems, and staff and patients were supported by learning disability link nurses, who were available and would attend departments if required to support patients.
- For patients with a learning disability who were undergoing surgical procedures, the learning disability team were involved at the pre-operative assessment and staff ensured they were usually first on the list to reduce their anxiety. Care workers or family members were able to stay with the patient if necessary right up until the operating theatre and able to help care for them on the wards if appropriate.
- We had previously identified that the critical care outreach service, which supported critically ill patients elsewhere in the hospital, had only one member of staff. This staff member also responded to emergencies and held follow-up assessments with discharged patients. We found there was now a critical

Summary of findings

outreach team of four full time staff available seven days a week 12 hours a day to assist with the care of critically ill patients throughout the hospital. Staff on the wards told us the outreach staff were accessible and available to attend wards and supported unwell patients.

Dementia

- We saw evidence of consideration for patients with an encroaching dementia. Some wards had a notice board that included information for relatives about dementia support. We saw that a 'This is me' form was available to enable families to provide personal information about patients, which would provide staff with an insight into the person's choices, preferences and needs. We did not see any evidence of this form having been completed. When there was a need for more support identified, further staffing to sit with that patient was available.
- Staff had undertaken dementia training, which was incorporated into the Trust's mandatory training programme for all staff.
- We were given an example of a patient who had a form of dementia who had been admitted for an operation. His wife visited the ward alone then they visited together. When he was admitted to the ward his wife was able to stay with him, accompany him to the operating theatre and was waiting for him on the ward on his return from recovery. His wife was able to stay overnight with him and help care for him during his stay in hospital. The staff thought the experience had shortened his length of stay in hospital. His wife has been asked to write about their experience and be part of a film talking about their experience to help train staff.

Access and flow

- Between April 2014 and April 2015 the trust had consistently failed to achieve the 95% standard for patients being seen and discharged from the emergency department within four hours. Performance had ranged between 77% (September 2014) to 92% (November 2014).
- There were occasions when activity in the emergency department increased to a degree that required a rapid response from the department and the hospital as a whole. At such times the response to 'crisis point' was reported to be good but the response from the rest of the hospital in the lead up to crisis point was reported as slow and more could have been done to avoid reaching the crisis in the first place.

Summary of findings

- Patients requiring acute stroke care were often unable to be admitted to the Stroke unit (Phoenix ward) due to delays in discharging patients. Beds were blocked and patients were being managed on other wards. Because of delays in discharge at the time of our inspection, 13 patients on the stroke ward had no current plan of discharge.
- Patients waiting for cardiac procedures experienced delays due to elective cardiac beds being used by medical patients who could not be accommodated on medical wards. This had resulted in only 84.8% of patients being treated within the target of referral to treatment in 18 weeks.
- At the time of the inspection many patients requiring an inpatient bed following elective surgery were being cancelled. This was mostly due to medical patients occupying beds on the surgical wards because all of the medical beds were full. This was as a result of high numbers of emergency medical admissions and patients on some wards staying longer due to delays in their discharge. Patients were told they may have their operations cancelled, on the day they were due to have the operation.
- The percentage of patients whose operation was cancelled and were not treated within 28 days had been above the England average for each quarter since October – December 2012. There were 32 cases between July and September 2014. Overall for the period April – June 2015 the trust had 97 cancelled operations which was the highest in England for this period.

Learning from complaints and concerns

- Staff were updated with any changes resulting from complaints or emails of concern as part of the daily safety briefing and newsletter. The newsletter for the medical assessment unit included general details about complaints and was updated fortnightly. It was also emailed to all staff to ensure a continuity of communication.
- There were processes for disseminating learning from complaints across the trust, with regular reports within the divisions, and through trust governance meetings to the board. Any trends and themes from complaints and concerns were discussed at ward level and division level if necessary. Good practice advice and required learning was identified and actions taken. Information was then disseminated to staff.
- The Patient Advice and Liaison (PALs) team were accessible and when required worked closely with the trust safeguarding team.

Overview of ratings

Our ratings for Royal Cornwall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Not rated	N/A	Requires improvement	N/A	Requires improvement
Medical care	Inadequate	N/A	N/A	Inadequate	N/A	Inadequate
Surgery	Good	N/A	N/A	Requires improvement	N/A	Good
Critical care	N/A			Requires improvement		Good
Overall	Inadequate	N/A	N/A	Requires improvement	N/A	Requires improvement

Our ratings for West Cornwall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	N/A	N/A	N/A	N/A	Good
Overall	Good	N/A	N/A	N/A	N/A	Good

Our ratings for Royal Cornwall Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	N/A	N/A	Requires improvement	N/A	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

We were given an example of a patient who had a form of dementia needing surgery. His wife visited the ward prior to him; he then visited with his wife. When he was admitted to the ward his wife was able to stay with him, accompany him to the operating theatre and was waiting for him on the ward on his return from recovery. His wife was able to stay overnight with him and help care for him during his stay in hospital. The staff thought the experience had lessened his length of stay in hospital. His wife has been asked to write about their experience and be part of a film talking about their experience which will be used to help train staff in the future.

There were patient ambassadors who carried out 'point of care observations' - spending time observing patients

and understanding how day to day routines on wards and interactions they have with staff may have an impact on a patient's wellbeing. The outcomes were shared with staff and formed part of future learning and development plans.

We spoke with the theatre educator who told us about the "bite size" learning that she had implemented that covered core skills for staff of all grades. She said the sessions were offered close to the work environment, on a rolling programme and had received good feedback. She said when staff were busy clinical teaching "goes by the way" but staff were able to attend short relevant sessions.

Areas for improvement

Action the trust MUST take to improve

The trust must ensure:

- Adequate nursing staffing are available and deployed in the emergency department to ensure people's care and treatment needs are met at all times.
- Sufficient numbers of suitably qualified staff are deployed at all times in the children's emergency department.
- All records in the emergency department are accurate, complete and contemporaneous.
- Equipment in the emergency department's resuscitation area is readily available.
- All electrical sockets in the children's emergency department are safe or out of reach.
- Action is taken to tackle ongoing performance issues in the emergency department, including flow and escalation.
- The emergency department is responsive at times of high patient attendance to mitigate the harmful effects of crowding – for example, through a structured and responsive management approach and control of the shop floor.
- Ensure the Stroke Unit (Phoenix ward) is responsive in its care for patients diagnosed with a new stroke. Caring for patients on other wards must not affect their access to therapeutic stroke care.
- Systems are consistently managed to identify the extent of outlying patients and ensure easy access for staff to appropriate consultant cover.
- Use of Cardiology unit beds for acute medical admissions does not adversely affect planned cardiology procedure admissions.
- Discharge planning arrangements are responsive. Processes varied and the resulting delays in discharges impacted on planned admissions and bed availability.
- Delays for patients with planned admissions to the critical care unit do not impact on patient outcomes.
- Reduce the number of patients who have their surgery cancelled and where this is unavoidable ensure that another date is booked and honoured within 28 days of the cancellation.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>17(2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.</p> <p>Procedures for assessing, monitoring and managing demand, flow and escalation were not found to be delivering consistently safe care for patients in the emergency department. Key performance targets were regularly being missed.</p> <p>17(2)(c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.</p> <p>A number of records in the emergency department were found to be incomplete, with omissions primarily relating to allergy information and fluid administration.</p> <p>A number of records were incomplete on wards seen within the medicine speciality. These included Phoenix ward, Escalation ward, Kerenza ward and Lowen ward. Record-keeping was not consistently maintained throughout the wards and departments. Some record-keeping did not ensure patients' safety.</p> <p>Some records storage did not ensure privacy and confidentiality. On the corridor in Wellington ward we saw records held in plastic files through which confidential information could be seen.</p> <p>At West Cornwall Hospital Of the 11 records we reviewed, three of the risk assessments for developing pressure ulcers and of falling were incomplete.</p> <p>On two occasions grade two pressure ulcers had been recorded on the assessment tool but one of these patients had no care plan advising the appropriate</p>

Requirement notices

treatment. Another record advised daily reassessment of risk but we could only find a recording of this after five days. Any professional caring for the patient would not have had up to date information to promote healing of the pressure ulcers.

one patient had a chart to monitor diabetes but there was no care plan informing staff of the actions required to ensure safe management of the condition and no other mention of diabetes in the record.

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12(2) (a) assessing the risks of health and safety of service users of receiving the care and treatment.

- Assessments, planning and delivery of care and treatment should :
- Be based on risk assessments that balance the needs and safety of people using the service with their rights and preferences.
- Include arrangements to respond appropriately and in good time to people's changing needs.

The emergency department was not always responsive at times of high patient attendance. There was no evidence of systematic strategies to mitigate the harmful effects of crowding, such as a structured and responsive management approach and control of the shop floor.

The Stroke Unit (Phoenix ward) was not responsive in its care for patients diagnosed with a new stroke. Because of delays in discharging patients, beds were blocked and patients were being managed on other wards. This affected their access to therapeutic stroke care.

The pressure of acute medical admissions had resulted in patients being admitted to the Cardiology unit beds, impacting on planned elective cardiology procedure admissions.

There were some delays for patients with planned admissions to the critical care unit. These delays would impact on patient outcomes.

Requirement notices

The systems in place to manage outlying patients were inconsistent, with inconsistent data collected to identify the extent of outlying patients and difficulties in some cases for staff to access consultant cover.

Discharge planning arrangements were not responsive. The processes in place varied and the resulting delays in discharges impacted on planned admissions and bed availability.

12(2) (b) Care and treatment must be provided in a safe way for service users.

Patients requiring elective surgery were having their surgery cancelled, sometimes more than once. Patients were not always being offered an alternative date for their surgery within the target 28 days of their operation being cancelled.

12(2) (d) Ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.

In the paediatric emergency department we found an unused and unprotected electrical socket in the waiting area. This was at ground level within the reach of children.

12(2) (f) Where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs.

We reported following our January 2014 inspection that equipment in the resuscitation area was not always readily available. During our recent inspection we found pump equipment was missing from the resuscitation area and staff was having difficulty locating replacements.

Enforcement actions

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	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>18.-(1) Sufficient number of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirement of this Part.</p> <ul style="list-style-type: none">• There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to consistently meet people's care and treatment needs.• Staffing levels and skill mix were not reviewed continuously and adapted to the changing need and circumstances of people using the service in the Higher Care Bay, Wellington Ward.• There was a failure to review and adapt staffing levels and skill mix in the emergency department in response to the changing needs of people using the service to ensure sufficient staff were deployed.• In the emergency department there were multiple unfilled nursing shifts observed and seen on review of previous and future working rosters. The current establishment of 12 nurses on a day shift and nine nurses on a night shift was not being achieved on a regular basis.• On three occasions during our inspection we found there were insufficient numbers of suitably qualified staff on duty in the children's accident and emergency area.