Care Quality Commission

Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospital

Quality Report

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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	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Inadequate
Surgery	Good
Critical care	Good

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.

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. The urgent care pathway within and beyond the hospital had problems which need focussed attention through a system wide approach.
- We had concerns around nursing staffing levels in the main and children's emergency area, 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 significantly 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 registered sick 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 non registered nursing staff 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.

We saw several areas of outstanding practice, including:

Summary of findings

- We were given an example of a patient with a form of dementia who needed surgery. His wife visited the ward alone before him then they went together. When he was admitted to the ward his wife was able to stay with him and accompany him to the operating theatre and she 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 to be used to help train staff.
- 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 patients have with staff may have an impact on their wellbeing. The outcomes were shared with staff and formed part of learning and development plans.
- The theatre educator 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.

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

Importantly, the trust must:

- 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 floe through the emergency department due to lack of bed availability. This requires a system wide response to facilitate rapid discharge from hospital.
- 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.

In addition, the trust should ensure that:

- There are adequate infection control procedures and equipment in the emergency department.
- A regime for the cleaning staff to follow in the emergency department, including a system that demonstrates when tasks have been completed, is introduced.
- All medicines are stored correctly.
- Systems to improve the reporting, monitoring and learning from incidents, complaints and risks in the emergency department are reviewed.

Summary of findings

- Arrangements for when medically expected patients are admitted through the emergency department are reviewed to reduce the impact on the department's ability to manage and treat emergency patients.
- All staff in the emergency department are aware of the guidance and protocols to ensure the National Early Warning Score is fully understood and followed as required.
- The treatment plan for patients receiving opiate pain relief is clear and supports those patients' specific needs.
- Areas of the environment are inadequate and suitable for patient use, particularly the stroke unit and the changing facilities in the Coronary Investigations Unit.
- There are sufficient staff with the right skills to enable ongoing management of the IT systems in critical care where currently there is a reliance on single members of staff.
- Where lockable notes trolleys are provided they are locked when unattended.
- Resuscitation trolleys are checked as required on either a daily or weekly basis according to trust policy.
- Hand hygiene dispensers are sited so as to be obvious to patients and staff and their regular use is encouraged.
- Review of outlying specialist surgical patients on general surgical wards is carried out more effectively to prevent delays in some patient discharges.
- All required staff attend level 1 and 2 adult safeguarding training as part of their ongoing mandatory training programme.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The emergency department was judged to be inadequate for safety and requiring improvement for responsiveness. Our main concerns were 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 significantly increased when the department expanded from nine to 23 major illness bays. There was a poor incident reporting culture and poor shared learning processes. Patients' care records were not being fully completed in all cases. The department struggled to manage flow and crowding, which 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 A&E performance targets and patients were experiencing long delays from their time of arrival to a decision to be admitted or discharged. While we found a number of areas that required significant improvement, staff working in the department were doing their utmost to ensure patients were as safe as possible in what were at times extremely difficult circumstances.
Medical care	Inadequate 	Some aspects of medical care were inadequate. Record-keeping was not consistently maintained throughout the wards and departments. Some record-keeping did not ensure the patients' safety as gaps in recording did not correctly and completely inform staff of care and treatment needed. Some aspects of the patient stroke pathway were not safe. The Stroke Unit (Phoenix ward) was not responsive in its care for patients diagnosed with a

new stroke. Because of delays in discharging patients some were being managed on other wards, which affected their access to therapeutic stroke care.
Nursing staffing levels and staff deployment in some medical areas did not protect people at all times. These areas included the Wellington ward higher care bay and the Escalation ward. There were vacancies for registered nurses and other grades of staff on most wards, with usage of bank and agency staff and recruitment of permanent staff ongoing.
Some areas of medicine at the hospital were not responsive. These included The cardiac Investigations Unit where 237 patients had had procedures cancelled between January and June 2015. Some patients had had their procedures cancelled two or three times. The pressure of acute medical admissions had resulted in patients being admitted to the Cardiology unit beds, with the result impacting on planned cardiology procedure admissions.
Systems to manage outlying medical patients admitted to non-medical wards were inconsistent. There was 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. Processes varied and the resulting delays in discharges impacted on planned admissions and bed availability.
The treatment plan for some patients receiving opiate pain relief was not clear and did not support those patients' specific needs.
Some areas of the environment were inadequate, particularly on the stroke unit.

Surgery **Good**

We found patient records were completed more fully than when we last inspected the hospital in January 2014. On some wards patient care records were stored in plain folders at the entrance to each bay. It was not obvious they were patient related. 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

Summary of findings

appropriately and maintaining patient confidentiality. In the Surgical Admissions Lounge patient notes and care records were stored in lockable cabinets that were shut but not locked. Patients booked for elective surgery that required a bed after surgery were regularly being cancelled due to medical patients having to be admitted to surgical wards because the medical wards were full. Staff in the surgical directorate were working hard to ensure their own systems functioned well, ensuring good flow of surgical patients when admitted for their surgery. For example, they were running a pilot of increased numbers of staff in each operating theatre to ensure patients were collected and taken from theatre in a timely manner, ensuring operating lists ran on time. They were also triaging patients to establish if they could be considered for day surgery instead of being admitted to an inpatient bed.

Critical care — **Good**

The critical care unit was not responsive to patients admitted to the unit. However, the pressures of bed capacity throughout the hospital impacted on the flow of patients through the unit. There were delays to some discharges to the wider hospital and some delays for patients with planned admissions to the critical care unit. These delays would adversely affect outcomes for patients.
The management of technology in the department continued to require sufficient staff with the advanced skills to manage the system. This is an ongoing piece of work for the trust.
The increase in outreach staff available was responsive to the needs of the unit and the wider hospital.

Royal Cornwall Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care

Detailed findings

Contents

Background to Royal Cornwall Hospital

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 including a consultant in emergency medicine, a 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 this inspection we inspected the following core services and domains at Royal Cornwall Hospital:

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

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.

Facts and data about Royal Cornwall Hospital

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 Michael's 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 attendances at Accident and Emergency in 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.

Detailed findings

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% agree or strongly agree that they would recommend the organisation as a place to work.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	N/A	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	N/A	N/A	Requires improvement	N/A	Good
Overall	Inadequate	N/A	N/A	Requires improvement	N/A	Requires improvement

Notes

1. These rating are based on the core services and domains looked at as part of this focussed inspection and what effect if any that has on the overall ratings for the services and location.

Urgent and emergency services

Safe	Inadequate
Effective	
Caring	
Responsive	Requires improvement
Well-led	
Overall	Requires improvement

Information about the service

The emergency department at Royal Cornwall Hospital in Truro is open 24 hours a day, seven days a week to provide an emergency service to the people of Cornwall and visitors to the area. It is the only emergency department in the county of Cornwall, supported by an urgent care department at the West Cornwall Hospital in Penzance, which is run by the same organisation.

The renovated emergency department was officially opened on 24 December 2013 and increased the number of treatment areas for major illness from nine to 23. The resuscitation area, which had not been renovated, consisted of three bays.

Nearly 79,000 patients attended the department last year (2014/15), averaging 216 per day. Of these, just over 6,800 were children. Weekly attendances varied between 1,198 and 1,955, with the summer months and school holiday periods seeing the biggest increases in numbers attending the department.

Patients were triaged when they arrived at the emergency department to ensure they reached the correct area for treatment (majors, minors or resuscitation).

The department had an eight-bedded clinical decision unit used for patients who needed ongoing observation or assessment before they were admitted to hospital, transferred or discharged.

There was a separate secure paediatric emergency area where children up to the age of 16 were assessed and treated. This area comprised a waiting room, two beds and a dedicated room for baby-feeding and nappy-changing.

Additionally, there were three cubicles used for the assessment and treatment of minor illness or injury. These could be used for both adults and children. Recent performance measures had shown the department had experienced difficulties with achieving the 95% standard for patients to be admitted, transferred or discharged within four hours.

Our inspection was unannounced and incorporated the emergency department because of concerns about crowding and patient flow, and the impact this could have on patient safety. We inspected the department on three days between 3 and 5 June 2015 and returned on the evening of 15 June 2015.

During our inspection we spoke to nine patients and 58 staff, including nurses, doctors, consultants, managers, support staff and ambulance staff. We also reviewed 12 care records and reviewed performance information from and about the trust.

Urgent and emergency services

Summary of findings

The emergency department was judged to be inadequate for safety and requiring improvement for responsiveness.

Our main concerns were around nursing staffing levels in the main and children's emergency area, which were placing patients at high risk of poor care. There was a poor incident reporting culture and poor shared learning processes. We saw patients' care records were not being fully completed in all cases. The department struggled 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. Processes to escalate deteriorating patients were not always being followed, placing patients at risk of harm.

Are urgent and emergency services safe?

Inadequate

People were not protected from avoidable harm.

We found nursing staffing levels were frequently below the existing establishment of 12 on days and nine on nights. 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.

At times nurses were caring for up to nine patients each and we observed some patients who did not receive the care they required as a result of the inadequate staffing.

Deteriorating patients were at risk because escalation processes were not always being followed.

We found the department was frequently taking medically expected patients (patients who had been referred by other healthcare professionals such as their GP) but additional staffing was not made available to manage this workload safely. There were not sufficient numbers of registered children's nurses in the children's emergency department to ensure one was on duty every shift.

Incident reporting was not given sufficient priority by staff. We were told actual incidents or 'near misses' were occurring regularly and had become 'normal' which led to staff being at times less likely to report an incident. There was no formal process to ensure learning from incidents was shared with all staff in the department.

We saw omissions in records and were concerned about medicine prescribing by nurses untrained in the use of the electronic prescribing system.

Only three quarters of departmental staff had completed their mandatory training, and we were told that attendance at training was difficult, with staff often being pulled back to work in the department because of demand and staffing issues.

Equipment was not always readily available in resuscitation and there were inadequate hand cleaning facilities for those attending the department.

Urgent and emergency services

Quality indicators showed the trust was not achieving required national standards in several areas, with these areas being known to increase the likelihood of mortality.

Incidents

- Incidents were reported using an electronic incident reporting system. This system was easily accessible to all staff on computers within the department.
- Between March 2014 and February 2015 there were nine 'serious incidents' recorded in the department, with three being categorised as 'sub-optimal care of the deteriorating patient' and two as 'unexpected death'. Full root cause analysis investigations were completed and clear recommendations made to prevent recurrence. However, we saw some repetition of the identified problems, which raised concerns that learning from incidents in the department was not robust.
- Staff told us they were aware of the incident reporting system and would usually report incidents where a patient or staff member had been affected. However, some nursing staff told us some actual or 'near miss' incidents went unreported due to them being 'normal occurrences' or due to having insufficient time to complete an incident report. In particular, staff shortages impacting on the department would not always be reported because these were considered to be 'the norm'. We were told of occasions when issues had not been reported because staff had become "de-sensitised" to the problems they were experiencing. This meant opportunities to learn and prevent harm were potentially being missed.
- We attended a monthly governance meeting where learning from incidents was discussed openly. All staff were invited to attend this meeting but the reality was that few were able to attend because of staffing issues and service demand. Wider sharing outside this meeting was not evident. Senior department staff told us the wider sharing of learning in the department "could be improved", particular with regard to nursing staff, and outside of the meeting only the individuals involved in an incident would receive any learning points unless staff took the time to read the meeting minutes. Staff we spoke with were unable to describe any learning that had arisen.
- We observed a patient with sepsis who had not received the appropriate level of observations and had no 'sepsis bundle' paperwork in place. The sepsis bundle is a protocol for treatment and management of patients who present with symptoms of sepsis infection and included immediate and ongoing actions that should be taken to treat and observe patients. We advised staff of our concerns at the time and immediate action was taken. However, when we followed this up on the incident reporting system we found no incident reports had been completed.
- The department had a consultant who led on mortality as part of their job plan. This consultant had responsibility for reviewing all deaths in the department and for attending the trust's monthly mortality meetings, feeding back to the departmental governance meeting. There were clear processes in place to review deaths in the department and learning from any deaths was shared at the governance meeting.

Duty of Candour

- The term 'Duty of Candour' was not recognised by the majority of staff we spoke with; however, all staff stated there was an open and honest culture with patients and their relatives when things went wrong. Compliance with Duty of Candour was recorded on the trust's electronic incident reporting system.

Mandatory training

- Completion of mandatory training within the department was variable. For example, only 59.1% of nursing staff required to complete 'Control of Infection' training had actually completed it, while 81.8% had completed 'Conflict Resolution'.
- 36 members of the emergency department's nursing staff group were trained in paediatric life support or advanced paediatric life support. During the previous 12 months there had been no occasions where the department did not have nursing staff who were trained in paediatric life support.
- Within the medical staff group only 39.5% of staff required to complete 'Safeguarding Adults Level 2' had actually completed it, while 97.4% had completed 'Equality, Diversity and Human Rights'. The overall completion rates for each staff group ranged between 70.8% and 77.4% for completion against required training, with the trust target being 100%. The target was previously 80% but was changed in December 2014.We were shown how rotas identified when nursing staff would be attending training sessions. However, one department manager told us staff would often have to

be pulled off training and back into the department because of staffing issues and demand. A junior doctor also told us it was sometimes difficult to attend departmental training because of operational demand.
- The department was in the process of recruiting into a new role specifically to support and develop learning for staff.

Safeguarding

- The department had dedicated link nurses for patients who were at risk of abuse, including specific domestic violence link nurses. These link nurses were available to assist with patients in the department if required and attended multiagency meetings, ensuring a linked approach by 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.
- We saw staff completing a safeguarding referral for a patient who had been brought into the department by ambulance. Staff told us they were confident in its use and were aware of their responsibilities to adhere to safeguarding procedures.
- Of the nursing staff in the department required to complete level 1 child protection training, 97% had completed it. 89.4% had completed level 2 and 37.9% had completed level 3. Of the medical staff in the department required to complete level 1 child protection training, 100% had completed it; 86.8% had completed level 2 and 36.4% had completed level 3. There was a clear safeguarding process and checklist for children attending the department and staff were knowledgeable in how this worked. We didn't have the opportunity to see any completed checklists during our inspection.
- We attended a departmental paediatric meeting, which was attended by seven staff members, including the safeguarding lead and consultant. We were told during this meeting that the computerised patient record system recorded all previous attendances and this was checked by the patient's lead clinician.
- There was no protocol in place to guide staff on what to do should a child leave the department before being seen. This was an action for the children's lead consultant following the paediatric departmental meeting and was necessary to ensure adequate safeguarding procedures are in place.
- There was a manual process to ensure letters were sent to health visitors, GPs and school nurses when a child attended the department. We were told there was a plan for all child attendances to be electronically shared with these professionals over the coming weeks.
- We were told all skull and long bone fractures in children under one year old were discussed with a paediatrician. This process was formalised in the department's safeguarding process.
- The documentation used within the department included risk assessments for falls, nutrition and pressure sores. Of the 12 records we reviewed, we found these had been completed where relevant.
- We observed a patient with dementia who had been brought in by ambulance. This patient was subject to a Deprivation of Liberty Safeguard (DoLS) under the Mental Capacity Act 2005 at their usual place of residence and the disability liaison nurse attended the department to commence the DoLS process for the duration of their stay in hospital. (DoLS is a process in legislation that provides protection against unnecessary restrictions on the liberty of individuals when it is necessary for their freedom to be restricted in their best interests. For example, a patient with severe learning disabilities could need to be prevented from leaving a care home without supervision because they are at high risk of coming to harm as a result of their lack of understanding of a given situation.) A nurse was not immediately available to be with this patient on a one-to-one basis but we later observed a nurse had been allocated and this was found to still be the case the following day.

Cleanliness, infection control and hygiene

- We spoke with the infection prevention and control link nurse who told us general cleaning in the department was good because there were cleaners dedicated to the emergency department. We observed the department to be clean and tidy, and saw cleaners regularly attending.
- The trust had a clear infection control policy and staff were seen to be adhering to it, being bare below the elbows, using appropriate personal protective equipment and washing hands between patients. Regular cleaning rounds were seen to take place and deep cleans undertaken when potentially infectious

patients had left an area. Additionally, we saw evidence that hand hygiene audits were completed regularly and, with two exceptions in the last 12 months, the department had been found to be compliant.

- There had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile reported in the department in the last 12 months.
- All of the cubicles in the majors department had hand washing facilities and hand gel readily available. In the clinical decision unit there was hand gel available by each bed.
- In the 2014 Care Quality Commission (CQC) survey, visitors to the department gave an average score of 8.9 out of 10 for cleanliness.
- A bed space environmental audit was completed in April 2015 and all checked areas were found to be compliant.
- A department environmental audit was completed in April 2015 and areas for improvement were recommended. The audit record did not show that any actions had been taken. One recommendation was for the sink in the clinical decision unit to be made operable so staff had access to suitable hand washing facilities; we observed during our inspection that it remained out of order.
- We found there was a lack of access to hand gel for people in the department, either as patients, visitors or staff. There was no hand gel available in the reception area and we were informed it had been removed because some people were found to be eating/drinking it. No alternative solution had been put in place. There was no hand gel available at either of the entrances to the clinical decision unit and none at either entrance to 'Majors 2'. There was a small hand pump on the reception desk in the paediatric department but this was not clearly labelled or visible and there were no other facilities in the waiting area or near the entrances.
- One of the toilets in the waiting area and one of the toilets in Majors 1 did not have any hand soap. We informed staff and cleaners promptly attended to restock these areas. We spoke to two members of the cleaning staff, who said there was no register or checklist to inform them or others when the toilets were last checked and/or cleaned. These were reportedly in place in other areas of the hospital but because the cleaning staff in the emergency department were dedicated to the department they just 'toured' the department at regular intervals but not against a specific schedule.

Environment and equipment

- Reception staff had good visibility of the entire waiting area and had quick access to majors or minors to summon help should a patient become unwell. There was a helipad directly outside the department to enable urgent cases to be brought to the hospital by helicopter and there was good access to imaging services.
- Resuscitation equipment throughout the department was clean and accessible. The units were sealed after being checked and a daily log was located with each unit, which showed regular checks of the equipment were being completed. We found one of the units had been used overnight and saw staff checking it thoroughly for stock before resealing it.
- There was good line of sight within the department from the nursing and medical stations and call bells were available in each cubicle.
- One nurse working in the resuscitation department raised concerns with us that equipment shortages were an ongoing difficulty. We were told pumps used in the department had to travel with patients when they were transferred to other areas of the hospital, and restocking this equipment from the central store was slow and difficult. During our inspection we observed one of the resuscitation bays was missing pump equipment and staff had to search around the hospital to locate replacements. This issue was also highlighted during our previous inspection in January 2014 and still remains a risk.
- In the paediatric department waiting area we observed a socket that did not have anything plugged into it. This socket was only a few inches off the ground, within the reach of a child, and had no form of cover or other protection. We spoke to the paediatric lead nurse about this concern and were told sockets in the department previously had covers but parents or carers would remove them to charge their phones and they would then go missing. We were told covers had been replaced on multiple occasions but they kept going missing. When we returned for the evening inspection we found this socket was still not protected.
- The corridor used to enter the department by arriving ambulance crews was being used for storage of dirty linen in two wheeled cages, a spare hospital bed, a cardboard recycling bin and other equipment. This made the corridor quite narrow and difficult to navigate with a stretcher or trolley.

- We observed a patient admitted to the resuscitation area requiring an ear probe for oxygen level monitoring. Staff could not find one in the department so a nurse had to leave to locate one from another area of the department. We were told by another nurse the ear probe was also not there the previous day but no action had been taken to source one.
- The resuscitation area was small with only three bays. We were told by department managers that renovation plans had been put together but had not progressed any further. We were told about one unwell patient overnight who had been moved out of resuscitation to make way for a cardiac arrest patient because the area was full. The senior nurse told us all four patients needed to be in the area but it wasn't possible because the area was too small.

Medicines

- Medicines, including controlled drugs, were appropriately stored, labelled, and recorded. Record books were completed clearly and provided effective monitoring and audit trails. All medicine stores were kept locked.
- Fridges used for the storing of medicines regularly had their temperatures checked. Checks were recorded in log books located with the fridges, and a clear process was in place with the pharmacy in the event of a temperature being found to be incorrect.
- On one occasion we found the decontamination room door was being held open by an oxygen cylinder. We informed the matron of this and action was taken immediately to store the cylinders appropriately.
- We reviewed 12 care records and found six did not have allergy information clearly recorded in the designated field. We were told that allergies were recorded on the electronic prescribing system but we were told not all agency staff had access to this system so there was a risk that allergies would not be easily identifiable in these cases.
- We observed an insecure cupboard containing various forms of medical fluids, including sodium chloride in various presentations and 20% glucose. The cupboard did not have any way of being secured. The corridor where this cupboard was located was not routinely observed but was accessible to anyone from within the department. We highlighted this to the matron before we left site because we were concerned about the risk this posed to patients and others. When we returned to the department 10 days later we observed the cupboard was still being used for storing fluids and was still insecure.
- We were told about an agency nurse who had been working overnight, with the shift being their first in the hospital. One senior nurse told us the agency nurse had not received any training on the electronic prescribing system and was therefore using paper-based prescribing for their patients. The senior nurse told us this practice was dangerous because there was a high risk of double doses being administered by staff using different systems. They also told us that at the end of the shift another staff member then had to retrospectively complete the electronic prescribing system from the paper-based records. We were told by another senior nurse that agency nurses who had not had training on the electronic prescribing system would not be allowed under any circumstances to administer medicines but we found there was no formal process or procedure in place to guide staff and ensure safe medicines administration by nursing staff who had not received the relevant training.
- We were told by one consultant that a patient with a deep vein thrombosis had stated they had had an injection into their stomach and he was concerned this had not been recorded on either the electronic or paper-based prescribing documents. Because the patient had said they had already had an injection they were not given a second but the consultant was concerned about the risk of that occurring in these circumstances. We reviewed the incident reporting system and found this incident had not been reported.

Records

- Care records in the clinical decision unit were kept locked away when not being used. Care records in the emergency department were kept in an open filing trolley for easy and regular access. This trolley was located next to the central desk area but was not supervised at all times, meaning there was a risk of breaching patient confidentiality.
- We viewed four records in the clinical decision unit and found none were fully complete. Two of the records had incomplete observations recorded; two did not have

allergy information recorded on the supplementary prescribing sheet; two did not have a complete set of timings attributed to all of the prescribed fluids. All four records had risk assessments completed.

- We viewed eight care records in the majors' area and found completed risk assessments in all cases. Regular observations in accordance with the National Early Warning Score (NEWS) chart were recorded in seven cases. Allergy information was not recorded clearly in the designated field in four of the records.
- Of the 12 care records we reviewed, five fluid administration charts did not have signatures to show they had been checked and none of the fluid administration charts were fully completed with start and finish times for each administration.

Assessing and responding to patient risk

- Patients arriving at the department had been, on average, triaged by a trained clinician within 15 minutes of their arrival between December 2014 and May 2015. This in line with national targets.
- All patients arriving into the department were triaged. In the majors' area, the nurse in charge triaged all patients arriving, directing patients to either resuscitation, majors or minor. The nurse in charge then entered the patient information onto the computer system. For minors, registered triage nurses undertook the triage process and assigned patients to the appropriate patient stream.
- In the 2014 CQC survey, the department scored 7.2 out of 10 for the length of time patients waited before being examined by a nurse or a doctor. This was a higher score than the national average.
- We observed the emergency phone being used by the ambulance service to provide a pre-alert to the department advising they were bringing in a particularly unwell patient. We saw staff in the department record information on a dedicated template and share this with others before the patient arrived. The majority of these patients were taken straight into resuscitation, where a bed and staff were awaiting their arrival.
- Reception staff told us they had not received training in the recognition of a deteriorating or severely unwell patient. Staff told us they had to use their "common sense" to summon assistance from a nurse when they thought it was required and they were not provided with any formal processes to follow outside of registering patients on the computer system. This placed patients in the waiting area at risk.
- In the clinical decision unit we observed regular observations were not being completed in accordance with escalation processes. Early warning systems were being used but not acted upon in all cases. The unit was staffed by one nurse and one healthcare assistant; during our inspection we observed the healthcare assistant being left alone to care for five patients while the nurse completed a patient transfer to a bed on a ward The healthcare assistant was alone for seven minutes before a nurse came to assist in the unit.
- Between March 2014 and February 2015 there were three serious incidents in the department, with one categorised as 'sub-optimal care of the deteriorating patient' and two as 'unexpected death'. These incidents highlighted a lack of escalation or increased observations in relation to the patient's National Early Warning Score (NEWS).
- We saw the department was using the NEWS system and had clear escalation processes in place, including senior medical review. However, in addition to the serious incidents above, we observed on two occasions these processes were not followed.
- In the clinical decision unit we observed one patient who had been admitted the previous night and diagnosed as having sepsis. 13.5 hours later there was no sepsis bundle paperwork in place and regular observations were not being completed in accordance with their early warning score. The patient required hourly observations but none had been recorded for over three hours. We immediately raised this with nursing staff and a full set of observations was completed; the new observations showed the patient's early warning score had increased, and nursing staff took immediate action to commence the sepsis bundle paperwork and arranged an urgent review by the medical team.
- We reviewed the trust's audit of patients diagnosed in ED with severe sepsis, which was mapped against the College of Emergency Medicine's standards. Between 15 March and 02 May 2015 performance against the standards varied widely in some areas. For example, the recording of observations on arrival had a standard of completion in 95% of cases but this was achieved only during one week in the period. In five out of the seven

weeks, the audit showed zero % had met this standard. Additionally, antibiotics should have been administered within the first hour after arrival in 50% of cases; this was only achieved in one week of the audit period. However, evidence of blood cultures being taken prior to leaving the department had a standard of completion in 95% of cases and this was achieved at 100% in every week of the audit period.

- In Majors 1 we observed one patient's record that showed they had been in the department for over two hours. This patient had a NEWS of five, requiring hourly observations, but after nearly two hours no further observations had been completed. We immediately informed the nurse in charge who told us a NEWS of five required four hourly observations. However, when this was checked against the protocol it was confirmed it should have been hourly. Observations were commenced immediately.
- There was no formalised 'rapid assessment and treatment' process within the department. We were told work was being undertaken to see how a senior-led assessment and treatment process could be introduced to support faster discharge of appropriate patients but there was no plan saying what this would look like or when it would be achieved.

Nursing staffing

- We were told by department managers that nursing staffing was the second highest risk for the department. They reported issues with retention and skill mix, as well as a need to increase numbers in the department. One manager told us they didn't think staffing in the department was safe, especially when the Majors 2 area was open.
- In September 2014, the NHS Emergency Care Intensive Support Team (ECIST) carried out a 'whole system review' of the services provided by NHS Kernow, which included the emergency department at the Royal Cornwall Hospital. Its report highlighted concerns about the numbers of nursing staff in the department and stated this concern should be placed on the risk register until significant risks had been mitigated. We reviewed the department's risk register and staffing levels were not recorded as a risk. However, we attended a monthly governance meeting and heard staffing levels being discussed as a concern.
- Department managers were writing a paper to go the board to increase their establishment from 12 registered nurses on a day shift to 14, and nine registered nurses on a night shift to 11. These revised numbers had been calculated in April 2014 using the Royal College of Nursing's (RCN) Baseline Emergency Staffing Tool (BEST), a tool that was launched in April 2013. The conclusion of this internal report highlighted that staffing levels in the emergency department "do not safely reflect the demands and dependency levels of patients…and fall far short of the safe recommended staffing levels 80% of the time through the 24hr cycle". When we spoke with a nurse in the clinical decision unit about a patient with sepsis we were told they had not been able to respond adequately to patients' needs in the department due to not having sufficient staff numbers for the types of patients on the unit.
- We reviewed the nursing rota for the forthcoming four weeks and observed multiple unfilled nursing shifts, with one week having 13 unfilled shifts. We were told these unfilled shifts would be put out to overtime within the department, and then to the in-hospital bank staff, before agency support would be requested. We were told by the matron that all staff, regardless of whether they were permanent, bank or agency, were entered onto the electronic rostering system. When we reviewed the previous six months' rotas we observed a high number of unfilled shifts, with no week having a full complement of staff. These gaps in staffing placed patients at risk.
- We were told by one department manager that nursing staffing numbers had not increased when the larger department opened. They told us the intention had been for the emergency department to be a single point of access to the hospital, with additional nurses being employed by the medical assessment unit to work in the emergency department and care for the medical patients. However, this had not happened, resulting in emergency department staffing numbers not being uplifted, placing a higher workload on the existing staffing establishment and therefore placing patients at risk.
- The planned staffing ratio in the clinical decision unit was one nurse to eight patients, supported by one healthcare assistant, which was the same as an inpatient ward. Department management told us they would like to see this increased to one nurse, one emergency nurse practitioner and one healthcare assistant but this was not currently achievable. We were told by one staff member that the healthcare assistant

would often be left alone in the clinical decision unit while patients were transferred to other areas of the hospital with the nurse. We observed this happen during our inspection, with five patients being left in the care of a healthcare assistant for seven minutes until another nurse came to assist from the majors' area.

- One nurse told us they regularly had to look after seven patients in Majors 2, which they considered to be "too many to provide adequate care and observation."
- We observed the emergency department to be understaffed on three occasions. On each occasion we found two nurses in Majors 1 were looking after seven patients each and one nurse in Majors 2 was looking after up to nine patients. The RCN's BEST tool suggests one nurse to three and a half patients. Additionally, on one of those occasions there was one nurse in resuscitation looking after two patients. The resuscitation nurse told us both patients should have been on the intensive therapy unit, and they felt the staffing levels at that time were "dangerous". Before we could discuss this with the senior nurse on duty a further patient arrived who required a resuscitation bed. We observed the nurse from Majors 2 being moved into resuscitation so there were two staff for the three patients, and the patients in Majors 2 were moved into Majors 1 as soon as beds were available. The shortages of staff did not enable continuous monitoring of patients and it appeared the staff were moved in a reactive rather than proactive way, which was not cohesive or consistent.
- During our evening inspection on 15 June the nurse in Majors 2 left the department for 15 minutes to undertake a patient transfer. This left one healthcare assistant and one assistant practitioner caring for eight patients. In Majors 1, there were two nurses with seven patients each, plus two patients waiting in the corridor for a bed.
- We observed delays for two patients in receiving pain relief because there were insufficient nurses available, either to administer or cross check. One delay was over 60 minutes; the other was almost two hours. We also observed delays in fluids being administered to two patients because staff were busy with other patients.
- There were no registered children's nurses on duty in the department on at least three shifts during our inspection, with cover being provided by adult nurses with a paediatric qualification. The Royal College of Nursing states there should be at least one registered children's nurse on duty every shift, or there should be a plan in place to achieve this. We were told recruitment was ongoing and one appointment had been confirmed but three of the vacancies were due to maternity leave and although the staff were already on leave the posts had not been covered. Rotas for the previous six months showed only one week in April had full cover, with the majority of weeks having three or more unfilled shifts.
- Nurses working in the paediatric emergency department worked alone. However, staff told us when the department was busy they could request assistance from a healthcare assistant from majors, minors or the paediatric wards.
- In CQC's Review of health services for Children Looked After and Safeguarding in Cornwall, undertaken in January 2015, it was reported that one nurse in the paediatric emergency department was insufficient and went on to recommend the hospital should "ensure sufficiency of paediatric expertise on the ED at all times"

The Matrons and Divisional Nurses utilise the 07:00 hours and 19:00 hours bed meetings to include staffing numbers and deployment in line with the 12 hour shifts. We were told by the site management team that matrons were required to cover their own staff shortages and only escalate where this was not possible after the shift had started. This then prompted the site management team to telephone around other areas to see if staff could be released to assist in the emergency department. The bed meetings we attended were not used to discuss staffing numbers across the site so identifying staff who could be moved to another area to assist was time-consuming and ineffective.

- We did not see any flexibility in staffing numbers and skill mix in response to patient's needs, and there were no acuity tools being applied regularly throughout a shift to inform staffing decisions.
- One senior nurse told us they were concerned the department was expected to continue taking medically expected patients (patients who had been referred by other healthcare professionals such as their GP, who would generally be admitted directly to a ward) even though they were already short staffed in the department. No additional staffing support was given to the department to manage this workload.
- We reviewed the previous six months' rotas for the advanced practitioners, healthcare assistants and emergency department assistants. These showed a

varying level of cover, with some day shifts only being covered by two of these staff groups, and some night shifts with only one (current establishment is four on days and three on nights). However, the majority of shifts were adequately staffed within these staffing groups.
- We did not observe a nursing handover. However, we were shown a template for the process to follow, and saw completed handover records showed a structured approach had been taken. The handover included a safety review.

Medical staffing

- We reviewed the medical rotas for May and June 2015 and saw actual cover against current establishment was being provided on almost every shift with a good skill mix.
- The rotas for May and June 2015 showed there was a minimum of a middle grade doctor (ST4) or above in the department at all times.
- The clinical lead for the department informed us medical staffing was the third greatest risk to the department because the current establishment was not sufficient to provide the levels of cover required. We were told additional funding had been secured but recruitment was ongoing and they were finding it difficult to attract applicants.
- In their September 2014 report, the NHS Emergency Care Intensive Support Team (ECIST) highlighted concerns about the numbers of medical staff in the department and stated this concern should be placed on the risk register until significant risks had been mitigated. We reviewed the department's risk register and staffing levels were not recorded as a risk.
- The trust's breakdown of medical staffing showed there was a small deficit in staff numbers with 31.4 whole time equivalent (WTE) in post against the establishment of 35.1 WTE spread across the department.
- We observed a morning medical handover. The process was consultant-led but did not follow a standardised structure and did not include a safety briefing for the doctors. The handover took place in the department using a computer to review the patients in the department. We were told handovers took place twice a day at 8am and 5pm.
- Consultant shifts covered between 8am and 10pm Monday to Friday, and 8am to 6.30pm Saturday and Sunday. However, we were told by the clinical lead that they often stayed beyond these hours, generally until midnight. The clinical lead told us funding had been agreed to increase the hours so cover could be achieved 8am to midnight seven days a week but it was not known how quickly this would be put in place. After 10pm, there was a named consultant on call throughout the night. The current establishment and rota did not provide 16 hours of consultant cover in the department as recommended by the College of Emergency Medicine based on the number of patients who used the department.

Major incident awareness and training

- The trust had a clear major incident and business continuity plan. Action cards were available for each role in the event of a major incident and department staff had access to them. The department had a dedicated equipment store for major incidents, which appeared well stocked with relevant items, including identification tabards.
- Staff told us the trust organised two major incident training sessions a year. A selection of department staff were sent to each training session to ensure sufficient staff had knowledge on a shift-by-shift basis. We were unable to obtain confirmation of the numbers who had attended before completing our inspection.
- The department had a decontamination room, located beside the resuscitation area. This had both internal and external access, ensuring patients could enter the room without first entering the hospital environment.
- Within the majors' area there were two isolation rooms, ensuring a safe environment could be maintained for all patients in the department in the event of contamination or infection concerns.
- The trust had security staff on site and we observed that when required they attended the department promptly. Reception staff had access to panic alarms that would alert on-site security staff, as well having immediate telephone access to their control room. Other staff in the department had the ability to raise an alarm through immediate telephone contact and through the department's alarm system.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Are urgent and emergency services caring?

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We have judged that the emergency department requires improvement in the area of responsiveness.

Flow issues and crowding in the department were evident throughout our inspection, with long delays between attendance and a decision being made to admit or discharge for a number of patients.

We found the hospital escalation process provided little support to the department and the trust default for capacity issues in medicine and surgery was for the emergency department to take on this additional workload without additional support

Within the department there was no evidence of systematic strategies to mitigate the crowding issues, such as a structured and responsive management approach and control of the 'shop floor'.

We saw that although care pathways existed, these were not always put into place for appropriate patients.

Children aged 16 and 17 years old would be treated in the same way as adults, using the main waiting room and assessment and treatment areas. The exception to this was if the patient was already known to the service, in which case they would consider utilising the paediatric area. There was no formal process to ensure children of this age group were seen and treated in the most appropriate area to meet their needs.

There were times when patients were moved to the clinical decision unit for four hour breach avoidance, and patients were seen queuing in the corridor on several occasions.

We found there was no formal process in place to ensure learning from complaints was shared throughout the department.

Service planning and delivery to meet the needs of local people

- The department was easily accessible with parking relatively nearby. There was also a drop off point close to the entrance.
- The main waiting area had sufficient space for the numbers of visitors throughout the course of our inspection, with adequate seating being available at all times.
- The paediatric department was open 24 hours a day, seven days a week, to provide emergency care and comfortable environment for children at all times.
- Weekly attendances varied widely, with the summer months seeing as many as 750 more patients attend the department in a week. The department did not have a formal process in place to respond to seasonal fluctuation, in particular with regard to staffing numbers.

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). In April 2015 82% of patients were seen and discharged from the unit within four hours.
- During our inspection we saw regular breaches of the four hour target. On the final morning of our inspection we observed 10 patients delayed beyond four hours when we arrived in the department, of which seven were medical patients requiring appropriate beds on a medical ward.
- Between April 2014 and April 2015 the trust was worse than the national average for the percentage of patients waiting four to 12 hours from the time a decision was made that they needed admitting, to the time they were

actually admitted, with exceptions in May, April and December 2014. In April 2015 the percentage of patients waiting four to 12 hours was just over 23%, with the national average being 10%.

- Department managers advised us patient flow was the highest risk for the department, but it was a whole-system issue and not something the department could respond to alone. There was evidence of some work being undertaken within the department, for example the exploration of a rapid assessment and treatment function; however, there were no timescales for trial or implementation of any such service.
- We were told by staff and department managers that on occasion patients were being moved to the clinical decision unit when they were approaching the four or 12 hour waiting time targets to avoid four hour breaches.
- One terminally ill patient who was in the majors' area was about to be moved to the clinical decision unit 10 minutes before they breached 12 hours in the department. We were told there were four inbound ambulances and there was no space in majors, so they were trying to make space. The patient was awaiting discharge home with a full care plan to support them at the end of their life and after we discussed the patient with the nurse in charge the decision was made to not cause additional distress by moving them to another area.
- The College of Emergency Medicine has produced guidance on overcrowding in emergency departments. In line with those guidelines the trust had a 'Capacity Management Escalation Plan' which contained clear criteria and action cards for escalation between its five levels of escalation, those being: 'green' – business as usual; 'amber' – moderate effect on services and patient safety; 'red' – severe and/or prolonged effect on services and high risk patient safety; 'red standby to black' – actions being taken in 'red' escalation not improving and pressures increasing; 'black' – extreme effect on services and very high risk to patient safety. Throughout our inspection the trust was on 'red' escalation; however, the escalation process identified two or more triggers were being met during our inspection that would have required a step up to 'red standby to black' status (continued failure in meeting the 4 hour target, surgical and medical take through the emergency department, all escalation beds open).
- The trust had been on 'black escalation status' between 16-24 February 2015 and 7-14 April 2015.
- We were told by department managers and nurses that when the department reached a 'crisis point' there was a very good response and support from the wider hospital. However, we were told the response in the lead up to a crisis was slow and more could be done to avoid reaching the crisis in the first place. We witnessed this issue when the department had been on 'medical take' (it was receiving patients who would ordinarily be admitted straight to a medical ward) and was at full capacity leading into a night shift, but there was little response through the escalation procedures. It was only the following morning that actions were seen to be put in place to support the department as crowding had become an issue before the morning bed meeting.
- There were bed meetings three times a day at fixed times. These meetings involved representatives from across the main hospital, community hospitals and the ambulance service. At this meeting staff discussed bed numbers, including confirmed discharges, but there was no set structure to the format. Staffing numbers were not discussed at the meetings we attended as a trust-wide consideration.
- Ambulance admissions over the past year ranged between 2,149 a month (November 2014) and 3,037 (July 2014). There was a target to complete the ambulance handover process within 15 minutes, in accordance with the NHS Standard Contract. However, for a large number of patients (ranging between 29% in June 2014 and 50% in September 2014) this had not been realised. In April 2015 45% of patient handovers were over 15 minutes, and eight percent were over 30 minutes.
- On 6 May 2015 there were 4 patients in the department who waited over 12 hours for admission into a hospital bed, the longest of which was 15 hours 43 minutes. Trust investigations reported each of these delays were due to a lack of available beds within other areas of the hospital, with the trust being on 'standby to black escalation'. The four investigation reports all stated the patients received appropriate care and treatment within the department, and that "on-going focus on discharge to support flow from [the emergency department]…" was an action being taken to prevent recurrence.
- We found the department to be on both medical and surgical takes because there were no beds within medicine or surgery. This was observed to have an impact on bed availability within the emergency department, with the department being full on multiple

occasions with patients queuing on ambulance stretchers or hospital trolleys and multiple breaches of the four hour target. We were told by department managers, consultants and nursing staff that the impact of receiving medically expected patients was significantly impacting on their ability to manage flow within the department.

- Department managers shared concerns with us about expected speciality patients (for example maxillofacial and ear, nose and throat) coming to the hospital through the emergency department, rather than direct to the appropriate specialist department within the hospital. We were told this was contributing to the crowding and flow issues within the department.
- We observed on one occasion three beds become available in the clinical decision unit; there were insufficient staff to undertake any transfers, preventing movement within the department itself.
- During our unannounced evening inspection on 15 June we observed two patients in the ambulance queue waiting for cubicles. One of these patients had arrived almost an hour earlier; the other had been waiting for just over 30 minutes. While the ambulance crews had been released, there was no movement through the department so any further arriving patients would also have needed to queue.
- The median average time for patients receiving treatment after arrival in the department in the last 12 months has varied between 35 minutes (December 2014) and 60 minutes (July 2014). In April 2015 the median average was 39 minutes. The national target is for all patients to receive treatment within 60 minutes.
- The number of patients leaving the department before being seen between April 2014 and April 2015 has been consistently below the national target of five percent, ranging between one and three percent.
- The site management team (bed/flow managers and coordinators) were based in an office very close to the department. During our inspection we observed the team frequently visiting the department and communicating well with the nurse in charge. Senior nurses told us the site team were easy to contact, even at times of high demand across the trust; however, they were concerned the escalation process was not effective in managing crowding and flow in the department.
- The department did not have a standard operating procedure to guide staff in how to effectively manage the department on a day to day basis. There was also no standard operating procedure in place to guide staff on the triage of patients.

Meeting people's individual needs

- The main reception desk had a lowered area so wheelchair users could interact with staff with ease, comfort and dignity.
- We saw wheelchairs were readily available inside the entrance to the department at all times.
- Staff told us interpreters were available through the main switchboard when required. Conversations were facilitated through a teleconference to allow all parties to talk together.
- We were told by staff that patients presenting with learning disabilities were highlighted on the computer system to ensure all staff were aware. Learning disability link nurses were available and would attend the department if required to support patients.
- Dementia training was incorporated into the trust's mandatory training programme for all staff.
- The department had a specific mental health triage tool; staff told us they were aware of this tool and were able to apply it where necessary.
- There was a separate paediatric department with its own waiting area. This was a secure environment, attached to the main waiting room and with direct access through to the minors' area. The waiting area was not overlooked by other waiting, assessment or treatment areas. However, we were told not all nurses working in the department were trained in triage and children would often be triaged in the main department.
- Within the paediatric department there were toys for varying ages and a television. Staff were able to play a variety of films through the television, and had a good selection of age appropriate films.
- The department did not have a specific area for patients aged 16 and 17 years. We were told by two nurses working in the paediatric department that 16 and 17 year olds would be treated in the same way as adults, using the main waiting room and assessment and treatment areas. The exception to this was if the patient was already known to the service, in which case they would consider utilising the paediatric area. There was

no formal process to support decision making in these circumstances to ensure children in this age range were seen and treated in the area of the department which was most suitable to their needs.

- There was no bariatric equipment available within the department; however, we were told appropriate equipment was readily available through the central equipment store when needed. We did not see a need for this equipment to be used during our inspection.
- We saw care bundles were available for patients with community acquired pneumonia, chronic obstructive pulmonary disease (COPD) exacerbation, heart failure, chest pain and sepsis.
- In their report, the Emergency Care Intensive Support Team (ECIST) highlighted a concern about access to crisis support for patients with mental health issues, with a 4 hour response for contact impacting on crowding issues within the department. We were provided with a copy of a standard operating procedure, which came into effect on 6 February 2013 and has an expiry of February 2016; this procedure stated telephone contact from the psychiatric team on call would be made within 30 minutes, and where necessary attendance in the department would be within 60 minutes. Staff told us sometimes the response would not be this prompt; however, we were not provided with any examples of delays that had been experienced and did not witness any patients requiring these services during our inspection.
- One terminally ill patient who was in the majors' area was about to be moved to the clinical decision unit 10 minutes before they breached 12 hours in the department; this was to create space for additional patients coming into the department. The patient was awaiting discharge home with a full care plan to support them at the end of their life. We expressed concerns with the nurse in charge because we did not feel this was appropriate for the patient's individual needs and would likely cause additional distress. The nurse in charge agreed and the decision was then made to not move the patient.

Learning from complaints and concerns

- The department received a total of 73 complaints between June 2014 and May 2015. This equated to 13% of all complaints received by the trust. Discharges and delays featured in the top four issues complained about in the department. 30% of the department's complaints were not completed within the 35 working day target.
- Staff told us if a complaint was received about them, or if they were involved with the patient's care, then they would be involved with the investigation process; for example, by providing statements or completing reflective practice. Once a complaint had been investigated, staff involved received individual feedback; however, a senior member of the department advised wider learning from complaints could be improved so those not directly involved could also take away lessons learned.
- There was no formal process to disseminate learning from complaints within the department, or to share learning more widely with other hospital departments. Staff we spoke with were unable to describe any learning that had arisen.
- Departmental complaints were investigated locally by a relevant manager. Feedback to the complainant depended on the nature of the complaint and investigation findings and would either be completed locally or centrally.

Are urgent and emergency services well-led?

Medical care (including older people's care)

Safe	Inadequate
Effective	
Caring	
Responsive	Inadequate
Well-led	
Overall	Inadequate

Information about the service

The Royal Cornwall Hospital has two medical assessment units and a further 15 medicine wards and departments. We visited medical assessment units, the ambulatory care centre and the medical day unit. Within the cardiac department we visited the cardiac investigations unit, coronary care unit and cardiac catheter lab. We also visited wards Carnkie, Phoenix (Stroke Unit), Roskear, Wellington, Kerenza, the Escalation ward and the endoscopy unit.

We spoke with eight patients, nine medical staff, 38 nursing staff and four administrative staff. We also looked at 25 sets of patient notes. Following the inspection we asked for performance data which we have reviewed and included in the report.

Summary of findings

Some aspects of medical care were inadequate.

Record keeping was not consistently maintained throughout the wards and departments. Some record keeping did not ensure the patient's safety as gaps in recording did not correctly and completely inform staff of care and treatment needed.

Some aspects of the patient stroke pathway did not protect patients from avoidable harm. 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.

Nursing staffing levels and staff deployment in some medical areas did not protect people at all times. These areas included the Wellington ward Higher Care bay and the Escalation ward. There were vacancies for registered nurses and other grades of staff on most wards with usage of bank and agency staff and recruitment of permeant staff ongoing.

Some areas of medicine at the hospital were not responsive. These included The cardiac Investigations Unit where 237 patients had procedures cancelled since January 2015, with some of these cancellations occurring 2-3 times. The pressure of acute medical admissions had resulted in patients being admitted to the Cardiology unit beds with the result impacting on planned elective cardiology procedure admissions.

Medical care (including older people's care)

Systems to manage outlying medical patients admitted to non-medical wards were inconsistent. There was 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. Processes varied and the resulting delays in discharges impacted on planned admissions and bed availability.

The treatment plan for some patients receiving opiate pain relief was not clear and did not support those patients' specific needs.

Some areas of the environment were inadequate, particularly on the stroke unit.

Are medical care services safe?

Inadequate

Some aspects of medical care were inadequate.

Nurse staffing levels and deployment in some medical areas was not safe. The areas of particular concern included the Wellington Higher Care bay and the Escalation ward. There were inadequate plans in place to manage the risks associated with leaving these wards areas short of staff. While there were systems in place to measure patient need, the number and grade of staff required did not consistently match the staffing levels seen.

Record keeping was not consistently maintained throughout the wards and departments. Some record keeping did not ensure the patient's safety by not correctly assessing, monitoring and managing risks to patients.

Some aspects of the patient stroke pathway did not protect patients from avoidable harm.. These included access to the stroke unit, specialist assessments and the discharge process. Systems in place for management of stroke patients did not ensure all patients were able to receive the care they needed. The NICE advises that speech and language assessment should be within 24 hours and no longer than 72 hours of a stroke. No Speech and Language Therapist (SALT) was accessible for stroke patients out of hours. This caused delays in patients receiving SALT assessments

The environments of the stroke unit (Phoenix ward) and the Cardiac Investigations unit which did not ensure the privacy, dignity and safety of patients using the service. These areas did not meet the patient's needs.

Incidents

- Incident reporting was encouraged and supported within the medical wards and departments. Staff explained that they were encouraged to report incidents and 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. Trust wide, 26 serious incidents were reported between March 2014 and February 2015.

- Medicine reported 3132 incidents in the period 01/06/2014 to 31/05/2015. The greater amount of these were pressure ulcers, slips, trips and falls.
- A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. There were two were surgical errors within the cardiology department which were classed as never events. We saw for one incident a Root Cause Analysis had taken place with investigation, lessons learnt and an action plan to prevent reoccurrence. Information received for the other even also indicated lessons had been learned and changes made to practice.
- The tissue viability service investigated when staff reported incidents of both hospital acquired pressure ulcers and those that were identified prior to a patient's admission. All grades 1-4 of pressure ulcers were reported and the tissue viability team checked to ensure correct reporting. As a result recent changes had been undertaken 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.
- The trust reviewed patient mortality through the Mortality Review committee and reported back monthly through the Governance Committee. We saw form minutes for March 2015 that the trust had received feedback and recommendations it would be taking forward.

Duty of Candour

- The 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.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing patient harm and harm free care. The Patient Safety Thermometer data showed the rates of pressure ulcers, falls and catheter acquired urinary tract infections were variable between December 2013 and December 2014 with no discernible trends.
- Audits of hand hygiene, ward cleaning and management of MRSA screening were also available outside wards.
- We saw that sense checks took place in all areas of medicine with the data gathered to identify pressure area damage management. For each sense check an action plan was completed to inform staff of the findings. The Medical Assessment Unit (MAU) Newsletter (Issue no.16) included information from the 'Sense Check' which had focussed that month on pressure ulcer prevention. This included the completion of pressure ulcer risk assessments in which the MAU scored 100% but identified that completion of associated care plans was poor.
- The tissue viability team were currently working with the falls team to look at similar trends to address any issues related to safety.

Cleanliness, infection control and hygiene

- Hand wash facilities were mostly available and the provision of personal protective equipment was seen throughout the hospital. We saw that some staff washed their hands between patients and used the sanitising hand gel appropriately. Other staff were seen to move from patient to patient without hand cleansing. The results for MAU showed that hand hygiene audit for May 2015 had been 80% compliance. This was a downward trend on the month previous.
- The Medical Day Unit had changed areas and we saw that hand hygiene arrangements and access to protective equipment had been considered and implemented.
- We observed that some wards did not have hand hygiene facilities outside of the bays for example on Carnkie ward and Phoenix ward. This would not support and prompt staff and visitors to maintain good hand hygiene
- Patients' records showed that screening of patients for Methicillin Resistant Staphylococcus Aureus (MRSA) took place and treatment was provided when required.

Environment and equipment

- The environment on Pheonix ward –the stroke ward was poor. The ward corridors were cluttered with equipment and we observed patients and visitors walking in this area, this may present a risk of trips and falls.
- We looked at the bathroom facilities on Pheonix ward. We saw that one shower was not suitable to be used by any patient with a level of physical impairment. A high step was needed to be negotiated to access the area and the space was limited for staff to support patients

who may not be stable to stand alone. No seating facility was available. The second shower available was accessible for patients with physical and mobility restrictions. However, this shower was outside of the ward area and so when staff assisted patients, this meant one or two staff were technically off the ward and this reduced staff numbers which may affect patient safety.

- Resuscitation equipment was reviewed in all areas and was seen to be complete and checked daily. We were told of a recent incident when a suction machine on the resuscitation trolley had malfunctioned during a cardiac arrest and had only worked intermittently. At the time staff acted quickly to find an alternative machine. An incident report was completed and feedback to all staff given through the safety briefing.
- The treatment plan for some patients receiving opiate pain relief was not clear and did not support those patients' specific needs. We saw that for some patients with recurring symptoms and pain the management was not consistent. The week prior to inspection five patients had been admitted to one ward for treatment. The management of opiates for some patients was not reviewed so that a consistent plan could be put in place, this impacted on staff time and ward resources. Staff on one ward audited the time spent as 5.5 hours in one day administering controlled drugs. This was a complex and ongoing problem requiring the trust to ensure patients individual needs were appropriately met. The details of the concerns were passed to the trust medical director for action.

Medicines

- Systems in place for electronic prescribing were in place. Staff told us that the electronic prescribing system was efficient and that it worked well in the hospital. Staff used the electronic prescribing to monitor and track which doctor wrote the prescription. This included the sepsis pathway and management of VTE, warfarin and antibiotic therapy. The electronic prescribing system also included interaction warnings when multiple medicines were prescribed. This was used to identify any risks to patients.
- We saw the pharmacy staff attending wards and departments and restocking areas as needed. We saw that most wards and departments recorded their medicine fridge temperatures to ensure the medicines stored were at the correct temperature. We were told by staff that Roskear ward were not doing this but were aware that they should be. We were unclear if this was being actioned.
- We visited the treatment room on the Medical Assessment Unit and found that whilst medicine cupboards were locked there was a packet of tablets left on the cupboard. These were accessible to the public when no staff were in the area. Staff could not account for these tablets being left out and secured them immediately
- The electronic prescribing system monitored the prescription and administration of venous thrombosis medication. This created an audit and prompts for when it was missed.

Records

- Record keeping was not consistently maintained throughout the wards and departments. Some record keeping did not ensure the patients safety. At the inspection we looked at 23 sets of patient's records relating to nursing care. These records were on the Medical Assessment Unit, Phoenix ward (Stroke ward), Escalation ward, Kerenza Ward, Lowen ward, Wellington ward and Carnkie ward. We saw that the nursing and observation records were not all completed and maintained. Two ward staff told us that records were not well maintained due to staffing constraints.
- As part of the actions put in place since our inspection 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) but we were advised this was part of a pilot of audit and this did not occur elsewhere in the hospital at this time. Cardiology wards were providing peer review of wards records involved in the audit for evidence of completion. In 52 weeks senior staff from the cardiology department audited approximately 1976 patient records. Results provided to us for Wellington and Roskear ward, the Coronary Care Unit and the Cardiac investigations unit demonstrated an improvement in record keeping. The remaining medical wards had not been included in this process.
- We looked at five sets of notes on the Escalation ward and found them to be incomplete. Out of the five, three did not have risk assessments fully completed. Four out

of the five had incomplete care plans. Three out of the five observation charts for pressure relief were seen to have gaps in timescales longer than their records identified as needed.

- On the Escalation ward, a patient was recorded to have pressure damage wound to their heel. A care plan for wound care was not put in place for staff to follow for 16 days after the patient's admission. On admission the same patient was assessed as requiring changes of position at two to four hour intervals, they were nursed on a pressure relieving mattress and were recorded on admission as being immobile and remaining in bed. Records were inconsistently maintained with gaps recorded in excess of 11 hours between changes of position.
- A further patient was identified as having a high level of incontinence. No risk assessment, care plan or information for staff to follow was available to ensure this patient's continence was managed. CARE rounding had been implemented and was recorded by staff on a record by the patient's bed. Despite the level of incontinence this patient had no recorded CARE rounding for a timescale in of excess of six hours.
- We looked at five sets of records on Phoenix ward. We saw all five care plans were not personalised, completed or updated. Reading the care plans did not consistently inform how to care for the patients. For example, one patients care plan made no reference to their diagnosis of diabetes.
- A patient on Phoenix ward was diagnosed as having a stroke with some weakness down one side of their body. The records of CARE rounding checks did not follow the plan of care in place for this patient. Pressure area checks were not all recorded as completed in the timescale indicated and so it was unclear if that care had been given.
- We looked at five sets of notes on Lowen ward these were also found to be incomplete. One patient receiving oxygen and needed assistance with this did not have a plan of care in place for oxygen management. Another patient did not have a care plan for staff to follow for access to the patient's blood line and management of their sepsis illness. One patient nursing documentation records indicated that a pressure sore had developed. At this point a nursing care plan was put in place to inform staff about the pressure area care needed. No records were seen to indicate this had been identified as a problem previously or how prevention was considered. The same patient was diagnosed on admission with faecal incontinence but no care plan was in place to inform staff how this was to be managed or to inform staff of the patient's personal care needs.
- We looked at six sets of notes on Kerenza ward. We saw gaps in of the observation records including care rounding, fluid balance charts, blood sugar charts and food record charts. We asked for documentation audits from the nurse in charge of that particular ward but they were not accessible. This ward had not been part of the documentation peer review.
- Some records storage did not ensure the privacy and confidentiality. On Wellington ward in the corridor saw records held in plastic files which records could be seen through. These records included personal details of patients including name, date of birth and prescription for blood products and did not protect patient confidentiality.

Safeguarding

- Staff described the route they would follow to make a safeguarding alert. They were clear about their responsibilities to ensure the safety of vulnerable patients.
- The safeguarding lead nurse confirmed that there was 60% compliance across trust staff for level 2 safeguarding training. This work was ongoing to increase the knowledge level of staff. The safeguarding team worked in conjunction with the mental health and learning disability team. The data for the medical division only was not available.
- The safeguarding team also monitored frequent attenders to the hospital and followed up by telephone with any patients who self discharged to support any patients who may be at risk. An example was given of a patient who frequently attended but following multidisciplinary working which had included the safeguarding team had reduced the amount of admissions to the hospital.
- There was in place a safeguarding operations team group which was attended by a representative of the medicine division and learning from this group was disseminated across the speciality.

Mandatory training

- The MAU staff Performance Assurance Framework identified that 91.2% of staff had competed manual

handling training. Staff also completed an infection control update, blood transfusion training, blood glucose training and Basic Life Support training. Trained staff also completed Intermediate Life Support Training. The MAU staff also attended personal safety and conflict resolution training.
- Induction at trust level was provided for agency staff and orientation at local level by staff on the ward.

Assessing and responding to patient risk

- The Sentinel Stroke National Audit Programme (SSNAP) July to September 2014 scored an E rating which is classed as the worst rating. Areas identified as failing included access to the stroke unit, specialist assessments, multidisciplinary working and discharge process.
- The hospital had a stroke pathway document in place which commenced in the Emergency Department and described care through the hospital. In March 2014 a review of stroke care was undertaken by an external reviewer. Recommendations were made and an action plan put in place. The action plan recorded the actions needed, however further to discussion with staff involved in stroke care management it was evident that none of the identified actions to improve outcomes for patients had yet been achieved or put in place
- The NICE guidance (CG68) advises that speech and language assessment should be within 24 hours and no longer than 72 hours of a stroke. No Speech and Language Therapist (SALT) was accessible for stroke patients out of hours. This caused delays in patients receiving SALT assessments; as a result we saw records of two patients who had not received the assessment over the weekend. These patients had either been 'Nil by Mouth' or staff had provided food and drinks which was recorded as making the patient cough. This created a risk of choking.
- We saw from patients records that prompt action was recorded when the stroke nurse was on duty. However only one stroke specialist nurse was employed and so when they were not available, actions for stroke patients could be was delayed. There was no stroke nurse on duty out of hours and weekends.
- Risk assessments for all medical patients were of a generic format and included in the admission pack for each patient. This included assessment of risk around pressure ulcers, nutritional screening, use of bedrails and manual handling risks. We looked at 25 sets of patient records and noted that seven records had a variety of incomplete risk assessments including risk assessments for falls.
- The use of early warning scores to assess patient deterioration was evident and well understood by staff. The integration of the Sepsis Alert within the National Early Warning Scores (NEWS) enabled staff to be aware of the pathway to follow to support the early treatment required for sepsis. The February 2015 audits of medical wards for compliance with NEWS completion varied. Most wards scored 100%. Four out of the 13 wards audited scored less highly. There were further sepsis guidelines available for staff on the hospital intranet and training provided for doctors and nurses. There was a consultant lead role to lead the development of the sepsis pathway. A sepsis audit was run by the College of Emergency Medicine which showed improvement in some areas. The audit and outcomes were disseminated to all staff through various staff meetings.
- The booking system in the Cardiac Catheter Lab was dependant on one person who understood and organised the booking system. In their absence no bookings took place as no other staff had the training to undertake this role. This could lead to a delay in patients being identified and booked for treatment. The risk register recorded that there was an extensive backlog of cases with long standing cancellations and failed re bookings. 44% of patients were cancelled in the first three months of this year. Three patients had been cancelled on the week of our inspection and a further three on the day of our evening inspection
- The systems in place to manage outlying patients were inconsistent and difficult for staff to access.

Staff explained that consultant cover for medical patients could sometimes be difficult to arrange. A system was in place for a consultant endocrinologist to see medical patients on surgical wards. This could only be facilitated should the consultant be referred by another consultant. Staff advised that valuable time was spent trying to action a review of a medical outlier. Staff confirmed that all patients were seen by the MAU 'Take Team' on admission but the problem was after that handover. Some staff said they gave up and asked MAU medical staff Level ST3 to visit and review the patient.

Nursing staffing

Medical care (including older people's care)

- Staffing in some medical areas was not safe. The trust risk register identified a shortfall of 100 registered nursing staff across the division in March 2015 with a plan for further review in July 2015.
- Staffing deployment on the Escalation ward was not consistently provided by the wards own staff to ensure a resilience of staff for the safety for patients. We saw that the ward had only nine permanent staff and had 13 staff whole time equivalent (WTE) vacancies for 25 beds this included 6 side rooms. The trust risk register identified in July 2014 that the ward had been opened without substantive staff in place. Monitoring was planned to ensure risks were updated. In October 2014 the risk register noted that due to the pressure of maintaining safe staffing levels on this ward the bed base was 'In theory capped at 12 beds to ensure we can maintain safe staffing levels although this is not always the case', the register noted that review was due on the 1st June 2015, no further update was noted. At the time of our inspection the ward had 25 beds open.
- Daily staffing allocation for the Escalation ward was four registered nurses and four HCA staff usually working a 12 hours shift. Due to the high number of vacancies this meant that staff were used from the hospital contingent workforce, agencies or from other wards and departments. Staff rota's showed that when agency and contingent workforce were used, these staff visited the ward regularly. Induction at trust level was provided for agency staff and orientation at local level by staff on the ward.
- We visited the acute respiratory ward, Wellington ward, which had in place a specific bay for patients with high care respiratory needs. This Higher Care bay had been in place since March 2015 and staff advised they provided care for level one and level two patients, level two patients by the hospitals own definition required a higher level of care, monitoring and more detailed observation/intervention. The dependency level of the patients was determined by nursing staff twice each day using this scale and reflected when changes in patient's conditions occurred and after the doctors ward round each day. The use of the staffing escalation plan to meet increased patients' needs was not evident. Staff we spoke with over the time of our inspection were not aware of the escalation tool used for this specific area.
- The Wellington Ward Higher Care bay had a staffing agreement of two registered nurses and two health care assistants (HCA) for the 12.5 day shift and one registered nurse and one HCA overnight. On the Friday of our inspection in the Wellington Ward Higher Care bay we saw one instance when the two registered nurses were not working in the Higher Care bay. We waited for ten minutes and during that time no registered nurses were available. During the time of our observation the staff in the Higher Care bay were a trainee assistant practitioner and a HCA. The registered nurse then returned to the Wellington ward Higher Care bay. A short while later, for nine minutes we observed the higher care bay was only staffed by a registered nurse and no other staff. At this time there were six level two dependency patients in the bay. 21 minutes later the remaining staffing complement for the bay returned. We observed that when breaks were arranged extra staff were not in place to replace those leaving the ward.
- We revisited the Higher Care Bay on another day in the evening. We saw that one registered nurse and one HCA (Assistant Practitioner) were staffing the bay for six patients with identified level two dependency. The registered nurse had taken one break that day and the ward sister had covered them being out of the bay. Staff told us that staff from Wellington ward covered breaks or breaks were not taken. We saw that for intravenous drugs or controlled drugs to be collected, the registered nurse had to leave the High Care bay. We saw medicine records which confirmed that this had happened at least twice for one patient. Staff confirmed that this was ongoing practice and during those times, on that shift, a HCA had been left alone in the Higher Care bay.
- The staffing ratio in this bay was reduced at night to one registered nurse and one HCA. However staff confirmed the dependency of the patients did not change at night time.
- The Coronary Care Unit had Three WTE registered nurse vacancies with staffing dependency currently being measured to establish how many staff were needed. The Coronary Care Unit (CCU) had been identified as needing four registered staff by day and three by night. If a Percutaneous Coronary Intervention (PCI) procedure was performed at night, a CCU nurse acted a runner for up to four hours and so leave the ward so CCU would be reduced to two registered nurses. Staff also identified that when shifts were up to full staff compliment the CCU may lose staff to other areas.
- Staffing was set at two registered nurses for the Coronary Investigations Unit (CIU) for 19 beds. On a

recent shift staff told us that a preceptorship nurse (newly qualified registered nurse with limited experience) was alone with HCA help on a night shift, CCU staff were available for support on the next ward. We did not see rota's to confirm this.

- Some staff roles were only able to be done by one skilled person, should that person not be available the role could not be filled by other staff with the required skills. These roles included the stroke specialist nurse and the booking staff for cardiology. This lack of resilience puts both staff and patients at risk.
- Staffing levels on the stroke ward (Phoenix ward) were seen to be below the planned level by one registered nurse for both the early and late shift for the first day of our inspection. There were currently 2.6 WTE registered nurse vacancies on Phoenix ward with the shortfall being met by agency staff.
- The stroke ward had recently been identified as needing more staff and this had been provided. Staff told us this was a morale boost for them. Further staffing review was taking place to identify if further staffing were needed. We looked at the staff rota for the stroke ward and saw that shifts were regularly not covered to meet the staffing establishment.
- There was no full time Speech and Language Therapist available to undertake the SALT assessment of the patients swallow. Some training had been provided for staff by the stroke nurse but was not sufficiently completed to enable assessment to take place consistently. In March 2015, 89.8 % patients had a swallow screen within four hours to establish their capability to eat and drink safely. However, 66.7% had a swallow assessment within 24 hours. We observed two patients in MAU who had to wait from Friday – when admitted – to Monday for a SALT assessment.
- The MAU had 3.75 WTE registered nurse vacancies and 6.78 WTE HCA vacancies. Recruitment was ongoing and agency staff were being used to supplement the shortfall. We looked at the previous weeks staffing and saw that over the week, eight registered nurse shifts were short and four HCA shifts short.

Medical staffing

- We saw that there was 24 hour consultant availability on the Medical Assessment Unit. Medical staff told us that they felt supported by the consultant and registrar level doctors and found them to be accessible out of hours. The proportion of consultants at the hospital was the same as the England average.
- There were 40 – 60 medical admissions per day in total via the emergency department (ED).
- The medical assessment unit had five consultants each morning and three MAU physicians up to 12 midday. There were five junior doctors on MAU. Between 12 midday and 8 pm new admissions were covered by the MAU consultants and one of the medical consultants looked after the medical patients in ED. At weekends the consultant work was divided between the MAU staff. Specialist consultants visited MAU by referral when needed, these included renal, gastroenterology, cardiology, neurology, endocrinology, respiratory and end of life care.
- There was a further 'Take team' of 2-3 doctors throughout the day and a 'Late support team' of junior doctors which included two junior doctors on duty overnight.
- The proportion of junior doctors was below the England average. Medical Assessment unit staff told us that they found the handover of information was adequate and included the handover of the bleeps in use. Junior doctor handover was not always attended by a registrar but as a registrar was on the ward or available, they were confident that they knew what was happening on the ward.
- One locum (temporary doctor) was in post to cover maternity leave and a further locum covers were used for winter pressures when need was identified. One or two junior doctor locums were required every day to cover holidays and sickness. They had all received the appropriate checks and induction.
- The cardiac Investigations Unit (CIU) was very busy and so had identified that there may be insufficient exposure to consultants for junior doctor training and support on a daily basis. As a result of the busy CIU a doctor was utilised for the Coronary Care Unit (CCU) on the CIU and so teaching of DC conversion (a cardiac procedure) was undertaken by a registrar for two sessions. Some insufficient exposure for medical staff to medical training opportunities was raised which may impact on the maintenance of their skills.

Medical care (including older people's care)

- The consultant cover for the stroke services was variable. On the first day of our inspection there was no stroke consultant or registrar available in the hospital. If needed the stroke services contacted the medical assessment unit for medical support.
- Some consultant rotas were not well managed. There were six cardiologists on the acute Percutaneous Coronary Intervention PCI rota which when staffed to cover holiday, left consultants working one in three weekends and split weekends.

Major incident awareness and training

- A major incident plan was in place which was last reviewed in 2013. Included in the plan were directions for the medicine team to follow.
- Staff were aware of the winter and summer pressures associated with the geographical location of the hospital. However, some commented that there appeared to be no relief from those pressures with an ongoing pressure of admissions.

Are medical care services effective?

Are medical care services caring?

Are medical care services responsive?

Inadequate

Some areas of medicine at the hospital were not responsive. People were not consistently able to access services in a timely way for treatment and some people experienced unacceptable waits for cardiac services. These included The cardiac Investigations Unit where 237 patients had been cancelled since January 2015, some of these 2-3 times. The pressure of acute medical admissions had resulted in patients being admitted to the Cardiology unit beds This had impacted on planned elective cardiology procedure admissions. Patients were frequently and consistently not able to access this service in a timely way and some patients experienced unacceptable waiting times.

The Stroke unit (Phoenix ward) was not responsive in its care for patients diagnosed with a new stroke. Because of delays in discharge beds were blocked and patients were being managed on other wards. This meant patients were not all able to access the care they needed and affected their access to therapeutic stroke care. Implementation of the trusts action plan as a result of an external review of the service had not yet evidenced any improvement in patients outcomes.

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.

We saw evidence of consideration for patients with a degree of dementia but limited evidence of how they were catered for specifically to meet their dementia needs.

The treatment plan for some patients receiving opiate pain relief was not clear and did not support those patients' specific needs.

Service planning and delivery to meet the needs of local people

- The Ambulatory Care Unit had been implemented 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. 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!" The unit was open for 11am to 11pm and was seen to run with efficiency.
- Patients we spoke with on a variety of wards were complementary about the care provided, they told us "The staff are great" and"staff are really good but run of 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.
- The new Medical Day Unit facilities were considered to be a significant improvement on the previous location.

Staff were very pleased to have a new location with greater space and facilities for treatment. This promoted a better environment which enabled more dignity and privacy for patients.

- The cardiac investigations unit (CIU) was not a dignified environment for patients. An external review took place in November 2013 with recommendations made. There was no male and female changing facility as currently patients had to change for procedures in a toilet. The CIU had six beds and a one chair for elective day cases. As this was a single bay, it had to be maintained as a single sex area and so the elective lists had to be managed accordingly. A small waiting room with no windows was used as a waiting room for up to 7 hours for some patients before their treatment.

Access and flow

- At the Royal Cornwall Hospital, average lengths of stay for elective procedures were shorter than the England average for cardiology. For non-elective procedures, average lengths of stay for general medical procedures were shorter than the England average.

The rehabilitation service at Royal Cornwall Hospital had noticeably shorter average lengths of stay

compared to the England average.

- In 2013 a review of cardiac services took place, key recommendations from that report were still awaiting implementation. There was a delay of cardiac procedures due to elective cardiac beds being used by medical outliers. Referral to treatment time standards were not met for Cardiology with 84.8% of patients meeting the referral to treatment percentage within 18 weeks.
- Staff told us that patients were admitted for cardiac procedures even when beds were not available and made ready for their procedure without a bed being confirmed. They told us they just 'hoped something comes up'. If a bed did not become available the procedure could be cancelled. They told us that patients would get very angry.
- 631 patients were cancelled in 2014 and 125 patients had been cancelled since January 2015, 44 of these had been cancelled twice or more. There were 65 cardiology elective operations cancelled within two hours of the schedule date, this included operations due to be performed in the cardiac Catheter Lab and interventional radiology between April and June 2015. All patients with long waiting times were risk rated by medical staff relating to clinical priority. If they received the highest rating and previously had been cancelled, patients were admitted anywhere in the hospital via the 'Take Team' and treated. To date there had been 91 unbooked pacing procedures for example synchronised pacing for heart failure and a further 277 unbooked other cardiac interventions for example Direct Current Conversions.
- The medicine division risk register recorded the risk of harm to patients if they could not be admitted for their procedure due to not protecting the 'B' bay for elective cardiac admissions in January 2014 and was for a further review 1st August 2015.
- The pre assessment service for patients undergoing cardiac procedures consisted of a telephone call to the patient from staff to discuss allergies and medication. Staff explained that a business case had been submitted a year ago to request a pre visit telephone call service. This would ensure information was obtained in advance of treatment and any risks could be identified. Staff told us that in the week of our inspection three patients had been turned back due to the lack of prior information. No action had been seen from the submission of this business case. Staff also explained that on the day of admission for the procedure consent was obtain directly prior to the procedure and may be rushed with patients being poorly informed and little information to inform their expectations for the procedure.
- Staff warned patients of likely cancellations at the last minute in order to try and manage their expectations so that if a cancellation was necessary it would be less of a surprise.
- On one day in the week prior to our inspection eight Direct Current Cardioversion case patients had changed in the toilets and were on trolleys, there was a backup in recovery and the patients had nowhere to return to in the department.
- On admission for Endoscopy staff told us that there was no formal pre assessment process apart from a telephone call from the booking team and reading preparation staff sent to the patient. Some patients were booked on the basis of a referral letter so were seen by the doctor for the first time when they arrived for endoscopy.

Medical care (including older people's care)

- The Stroke unit (Phoenix ward) was not responsive in its care for patients diagnosed with a new stroke. The trust risk register identified in April 2014 the failure to meet and treat stroke patients within guidelines. This was identified as due to lack of staffing and was due to be reviewed September 2014, no further updates were recorded.
- Because of delays in discharge at the time of our inspection 13 patients on the stroke ward had no current plan of discharge. They were awaiting transfer to for stroke rehabilitation of packages of care in the community. This meant that of the 20 stroke unit beds only seven were available to receive new patients.
- As a result, newly diagnosed stroke patients were seen to be cared for on other wards. We were advised by staff that most stroke patients spent at least two days on the medical assessment unit. This meant that patients may not get the timely specialist access they needed from therapist and specialist staff. During the inspection we saw five patients with a diagnosis requiring admission to the stroke ward that remained for two to three days on the MAU. The result of this was that some patients did not receive the electronic VTE treatment or assessments of their ability to swallow in a timely way. This is not in line with NICE guidance.
- One set of notes on Carnkie ward showed that that a patient admitted to the ward with a possible diagnosis of a stroke who was maintained Nil by Mouth did not have a speech and language therapist (SALT) assessment for four days. The patient did not have an assessment until they had experienced a choking episode. Once assessed a soft diet was advised.
- The stroke pathway for patients receiving thrombolysis treatment meant that they had to go post treatment to the Intensive Care Unit. This was because there was insufficient staff for the observation needed on the stroke ward. Those patients may then not be able to be discharged back to the stroke ward, because the stroke ward did not have any beds available. The time period for ICU care was 12 hours but staff said would be exceeded whilst waiting for a stroke unit bed.
- We reviewed the data for time from admission to the stroke unit for the month of May 2015. Stroke patients were aimed to be on the stroke unit within four hours. We saw that 27 patients arrived on the stroke unit over the four hours advised. One patient waited 121 hours. 34.5 % of patients arrived on the ward within four hours, 59.6% of patients time was spent time on the stroke ward instead of the 90% guideline.
- Bed meetings took place twice each day and identified medical patients on outlying wards. These patients were being treated and cared for on wards which were not the correct ward for their medical diagnosis. This was because the medical wards were blocked by patients waiting for discharge or transfer. The medical patients being managed on surgical wards were not cared for by medical nurses, however staff told us generally these patients were those who presented with a lower medical risk.
- The twice daily bed meetings identified patients planned for discharge and patients estimated for admission. The meeting also included patients in the emergency department and ambulatory care department waiting for admission. There did not appear to be a standard operating procedure for all staff to follow the same process to manage bed vacancies and discharges. This meant that when the system had worked well, this success could not be repeated as it was not managed to develop the process. Staff told us about a recent incident when a patient who was due to be discharged was sat out of their bed and a new patient admitted to the same bed whilst they remained sat there for 50 minutes.
- Discharge planning arrangements were not responsive. This issue was highlighted on the medical division risk register in 2011. We reviewed the hospital discharge procedure which identified the need to start planning discharge on admission. We saw that in practice this did not take place as at the time of our inspection the hospital had 72 patients identified as fit for discharge but with no date in place. This was due to several reasons but included issues outside of the hospitals control with patients waiting for packages of care and ongoing treatment and therapy. The policy was reflected by staff when we asked about discharges at night. Staff assured us that these discharges were avoided unless the patient was in agreement. Discharge late at night was avoided. Data provided showed very few discharges after 10pm.
- Discharge arrangements varied from ward to ward and no discharge lounge was in operation to facilitate beds being made available in a timely way for admissions. Some wards had a discharge coordinator and some

wards expected the nursing staff to undertake this role. There was little pre planning in place to enable a rapid response to discharge and nursing staff may not have the network connections or time needed for effective complex discharge. Plans were in place to encourage staff to consider any patients who may be considered for discharge the day before. However, in some instances wards had patients waiting for packages of care or places to transfer to and exact dates were not known. There was no system evident at ward level to facilitate or chase any progress to improve responsive discharge and so improve flow through the hospital.

- We observed a delay in a fast track discharge because a care package could not be restarted. The fast track delay was currently 15 days at the time of inspection. This meant that a patient who needed to return home quickly was still waiting over two weeks.
- The endoscopy suite was currently undergoing renovation and staff were continuing to provide a service throughout the building work. Endoscopy lists were rarely cancelled. No formal pre assessment was in place for patients other than a call from the booking office and literature available. This meant that for those patients referred by their GP the specialist would only see the patient on the day of the endoscopy.
- We saw that the recording data for patients on wards outside of their speciality (outliers) was varied in how it was managed. This may mean that the trust overall view of patient status was incorrect. On Roskear ward they had seven patients recorded as clinically stable but were in fact waiting for surgery. The electronic system recorded them as fit for discharge; this inaccuracy was currently being addressed.

Meeting people's individual needs

- We saw that for a patient with complex needs requiring extra support had been provided by a one to one nurse. Records were maintained of multi-disciplinary working to enable the persons complex needs to be addressed
- We saw evidence of consideration for patients with a degree of dementia. Some wards had a notice board which 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. Staff told us that when the need for more support was identified, further staffing to sit with that patient was available. Some wards were not aware of any specific dementia support but had patients with a degree of dementia on the ward. Records showed that 864 medical and nursing staff from the emergency and medicine division line dementia training.
- Translation telephone services were available. Some staff were not clear how these services could be accessed; however other staff were able to provide the information.
- Staff were aware of the need for support for patients with a learning disability. Staff explained the support provided and how extra facilities and access to the learning disability support nurse was accessed. We saw that when needed a carer could stay on the ward with the patient to ensure their comfort and support.

Learning from complaints and concerns

- All complaints which related to the medical department were investigated by the managers for each area and all complaints received a formal response. 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 MAU was seen to include general details about complaints and was updated fortnightly and was also emailed to all staff to ensure a continuity of communication.
- There had been 206 complaints about the medicine speciality June 2014- May 2015. However, this did also cover ED. The leading theme for complaints was poor communication between patients / relatives/ carer and medical staff.

Are medical care services well-led?

Surgery

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

Information about the service

Surgery services at the Royal Cornwall Hospital consist of 15 operating theatres (based in the Trelawney Wing and Tower Block). They provide emergency and elective surgery and recovery to adults and children. There is a preoperative assessment unit in Trelawney Wing (Theatre Direct) and in Tower Block (Surgical Admissions Lounge) where patients are admitted prior to surgery either in advance or on the same day. Patients also spend time on these units postoperatively until they are ready to go home or be transferred to a specialist ward.

There are seven surgical wards that cater for emergency admissions, trauma and routine post-operative recovery.

We spoke with 19 nursing and care staff, six medical staff including consultants, middle grade and junior doctors, two operating department practitioners and two administrative staff.

We spoke with six patients and looked at 13 sets of patient notes and observational records.

Compliance actions were given where breaches of regulation 20 and 9 of the Health and Social Care Act 2008 were identified following the comprehensive inspection carried out in January 2014. They related to incomplete patient records and observational records; patient records stored in areas that were not secured and at times left unattended; equipment in the wrong place sometimes meant operating lists started late whilst staff found the equipment; at times surgical staff were not able to meet the patient prior to the operation in a suitable environment to gain consent; cancelled or delayed operations due to lack of available beds in the hospital as a whole.

We did not visit NewlynTheatres, interventional radiography, ophthalmology or stand alone day surgery services that did not fall under the surgical division such as dermatology. We did not visit critical care or cardiology where some patients may be admitted following major surgery.

Surgery

Summary of findings

We found patient records were completed more fully than when we last inspected the hospital in January 2014. Patient notes and observational records that we looked at were nearly all fully completed. On some wards patient care records were stored in plain folders at the entrance to each bay. It was not obvious they were patient related. 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. In the Surgical Admissions Lounge patient notes and care records were stored in lockable cabinets that were shut but not locked.

We found that patients booked for elective surgery that required a bed after surgery were regularly being cancelled 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. Staff in the surgical directorate were working hard to ensure their own systems functioned well, ensuring good flow of surgical patients when admitted for their surgery. For example, they were running a pilot of increased numbers of staff in each operating theatre to ensure patient's were collected and taken from theatre in a timely manner ensuring operating lists ran on time. They were also triaging patients to establish if they could be considered for day surgery instead of being admitted to an inpatient bed.

The number of elective operations cancelled between January and April 2015 was 217, there were 88 in January, 79 in February and 50 in March 2015. for the period of April – June 2015 there were 5239 planned elective operations. Of these 284 (5.42%) had been cancelled

Emergency surgery and day surgery where patients did not require an inpatient bed following surgery were continuing to function well.

Are surgery services safe?

Good

Staff were aware of how to report incidents and received feedback. The trust investigated serious incidences and any learning and change of practice required was disseminated to relevant staff. With action plans in place to ensure the learning had been embedded into practice.

All areas of the surgical division we visited were clean and hygienic at the time of the inspection. Hand hygiene practices were not always adhered to by patients, visitors or staff when entering ward areas.

Most of the 13 patient records we reviewed were fully completed and stored securely. The Five Steps to Safer Surgery Checklists were completed routinely and a system of a regular audit was in place to ensure good practice continued. Since the last inspection when we found records were "stored in areas that were not secured and at times unattended" the trust had acquired notes trolleys that were lockable. All wards, but one, we visited the patient records and medical notes were stored in the cabinets and they were locked after each person accessed the trolley.

Bite size training sessions that covered core skills topics, for all grades of staff, had been organised and were delivered on a rolling programme. They were said to be very popular and as they were short sessions in the work place were well attended.

Incidents

- Staff we spoke with told us they regularly reported incidents. Ward managers told us they fed information about incidents and the learning from the incidents to staff via team meetings, daily safety briefings and memos displayed in staff areas. Staff told us of occasions when they completed an incident form if staff were moved to work in another area and it meant they were under the recommended safe staffing levels for the number of patients they had on the ward. Staff did not feel reporting the incidents made an immediate difference but hoped in time it would.

- The trust reported 17 serious incidents between March 2014 and February 2015. They had all being investigated and the outcomes shared with relevant staff for learning and development purposes.
- One never event (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) had been reported between March 2014 and February 2015. The incident had been fully investigated and new procedures put in place to reduce the risk of the same incident occurring in the future.
- In the divisional quarterly report for theatres and anaesthetics there were 18 in hospital deaths between January and March 2015, 50% had been reviewed by 20 April 2015. There had been three Mortality Review Committee (MRC) meetings during the quarter where six cases/reviews were discussed. The report showed that despite the requirement for monthly mortality reports to be submitted to the MRC by specialties no reports had been submitted by theatres and anaesthetics. This meant they were not complying with the trust policy. This may mean that not all deaths were being discussed and learning opportunities may not be captured.
- Cancelled operations were not reported on the electronic incident reporting system as they were captured by the general computer system used throughout the hospital.

Duty Of Candour

- Staff across the surgery division recognised the term "Duty of Candour" (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided).Their description about how complaints and concerns were managed assured us they were implementing the principles of the Duty of Candour and kept patients informed about how their concerns and complaints were being managed. We were told senior staff had received some training around Duty of Candour.

Safety thermometer

- Wards undertook regular assessments using the safety thermometer, which is a tool for measuring and monitoring patient harm and harm free care. Results showed there were variable rates, showing no trend, of pressure ulcers, falls and catheter acquired urinary tract infections between December 2013 and December 2014. The trust had initiatives in place for reducing falls and incidences of pressure sores. These were regularly audited and learning implemented.
- In the quarterly divisional report (January to March 2105) for surgery, trauma and orthopaedics slips, trips and falls had seen a decrease of 12% compared to the previous year.

Cleanliness, infection control and hygiene

- Staff reported some issues with the cleanliness of their environment since an external contractor had taken over the cleaning services. They said when they had regular staff who were used to the environment it was fine but when staff were moved to and from unfamiliar environments the cleanliness was not so good. One ward sister said she had regular discussions with the cleaning supervisor about the cleaning on their ward and felt that "things were improving". The matron in Trelawney Wing operating theatres said that they were in discussion with the supervisor as general cleaning of the operating theatre suite (not including the theatres themselves) was regularly not carried out from Friday afternoon until Monday morning. This sometimes led to bins overflowing and large amounts of dust from the operating theatres ventilation systems collecting in general areas of the theatre suite.
- The wards and departments we visited, especially those that had undergone recent renovation, were clean and tidy. Gloves and aprons were readily available. There were hand washing sinks with paper towels and foot operated pedal bins available throughout the wards and departments in the surgical division.
- We saw some staff using the hand gel dispensers placed at ward and department entrances, although these were not always very visible. We observed during a one hour and 45 minute period on one ward 16 staff and patients entering the ward and not using hand gel and four leaving the ward who did not use the hand gel.
- In April 2015 the surgical wards were 98% compliant with the 'basic compliance observation' form in relation to 'five moments of hand hygiene' and bare below the elbows compliance.
- Possible infection risk for elective surgery patients on the same ward as medical patients had been bought to the attention of the infection control team and was subject to ongoing discussion.

- Each patient was screened for methicillin resistant Staphylococcus aureus (MRSA) pre admission. There were protocols in place for managing patients who were positive for MRSA.
- Trust wide there had been seven cases of C.difficle between April 2014 and March 2015. Four had been in April and May 2014 with none reported since December 2014.
- Trust wide there had been two MRSA bacteraemia infection reported between April 2014 and March 2015 one being in May 2014 and the other in December 2014.
- The trust undertook surgical site infection surveillance for fractured neck of femur and knee replacement surgery. Readmission rates for surgical site infections between January and March 2015 were 3.3% for two out of 60 procedures. This was an increase from July to September 2014 where the rate was 1.8% for one out of 109 cases. The rate for neck of femur repairs was 1% between January and March 2015 for one case out of 92 procedures. Which was a slight improvement from July to September 2014 when it was 1.1% for one case out of 87 procedures. There were no readmissions for surgical site infections following total knee replacements.

Environment and equipment

- The operating theatres and recovery areas had resuscitation equipment appropriate for adults and children. The surgical wards had resuscitation equipment appropriate for adults. We saw all the equipment was checked daily (routine) and weekly (in depth including medications) apart from on one ward where the equipment had not been checked for 3 days in May 2015. The weekly checks on the same ward had only been carried out on one of the four weeks in May 2015. We told the trust what we had found and received assurances staff would be reminded of the importance of regular checking.
- During the last inspection (in January 2014) we were told that operations sometimes started late due to equipment not being in the right place. We were told this had now improved as briefing prior to an operating list starting highlighted if any equipment was missing or not available. This allowed for the shift manager to access the equipment and for the timing of operations on the list to be moved if necessary, until staff were sure the correct equipment was available.
- Since the last inspection the Trelawney Wing operating theatres equipment room had undergone some improvement. This meant items from the sterile supplies department (SSD) were easily identified when required meaning trolleys for operations could be set up more quickly and efficiently.
- A theatre sister told us they had good working relations with SSD who responded quickly to unexpected or unusual requests for equipment.

Medicines

- On wards and departments we visited we saw medicines were securely stored. Controlled medicines were stored in separate locked cupboards and checked by two registered nurses each day.
- In most areas there was piped oxygen. The equipment was serviced as required. Any free standing cylinders we did see were safely stored and relevant signage was in place.
- We were told the medicines were checked and replenished as required by the pharmacy team. We were told the pharmacy team were available for advice 24 hours a day.
- We saw that up to date drug formularies were available in the operating theatres and on the wards we visited.
- We saw allergies were clearly documented in the patient's notes, pre and post operatively. Allergy status was also checked during consultation with the anaesthetist and at the point of administering anaesthetic medication.
- We were not made aware of any issues of delayed discharge due to waiting for medicines to take home.

Records

- During the last inspection we found that patient records were incomplete in relation to observational records (temperature, pulse etc.) and there was missing or conflicting information in patient records (care plans and nursing notes). During this inspection we looked at 13 sets of patient records and observational records on eight wards. We found them to be generally complete with three observation charts not completed up to date and one patient with a leg ulcer with no care plan, although it was clear the leg ulcer was being cared for regularly.
- Staff told us there had been "a drive" within the trust to ensure care plans were completed. They said they had not attended any formal training, in completing documentation, since the last inspection. Staff said documentation completion was discussed at team

meetings and in newsletters circulated by their departments. Staff thought records were audited regularly some on a planned basis and other randomly. Managers told us about the "test your care" audits that had taken place around improving documentation. The results of which were discussed at team/ward meetings.

- Risk assessments were seen in all sets of notes reviewed. They had been reviewed where relevant and if a risk identified an appropriate care plan had been created.
- We saw five completed Five Steps to Safer Surgery Checklists in postoperative records we reviewed. We were told there were regular audits of the use of the checklist. Staff told us there was one week each month where all checklists were checked for full completion. As staff were aware of this audit at the time theatre sisters told us they also carried out spot checks of the checklists to ensure compliance was ongoing.
- Since the last inspection when we found records were "stored in areas that were not secured and at times unattended". The trust had since acquired notes trolleys that were lockable. On all, but one, ward we visited the patient records and medical notes were stored in the cabinets and they were locked after each person accessed the trolley. In the Surgical Admissions Lounge patient notes and care records were stored in lockable cabinets that were shut but not locked.

Safeguarding

- Information supplied by the trust showed 67.8% of staff in the theatre, surgery and anaesthetics division, as of 31 March 2015, had attended level 1 adult safeguarding training and 53.1% had attended level 2 training. Until training attendance had improved the trust had prioritised all band 6 nurses and above for training to ensure there was always a person on shift who had completed level 2 training.
- Most of the staff we spoke with told us they had attended safeguarding training. Staff were able to describe elements of the Mental Capacity Act 2005 and associated Deprivation of Liberty safeguards (DOLs). One member of staff told us they had made a DOLs application that day and explained the process they had followed.
- Staff knew how to report any safeguarding concerns and felt confident their concerns would be taken seriously. Staff on some wards told us there was a safeguarding file they would refer to if they were unsure of how to report a concern.
- The trust employed a safeguarding lead nurse. Staff were aware of them and how to contact them.

Mandatory training

- Staff we spoke with told us they usually attended their mandatory training. On one ward we saw records showing out of 80 staff eight registered nurses were overdue some mandatory training.
- Training records for the surgical directorate showed individual training records for each member of staff. The main areas where staff had not completed mandatory training were adult safeguarding, manual handling and health and safety at work.
- We spoke with the theatre educator who told us about the "bite size" learning that she had implemented. It covered core skills for support 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 are busy clinical teaching "goes by the way" but staff were able to attend short relevant sessions. There were 15 sessions run in the last year that included sessions about barriers to communication in operating theatres, induction to the anaesthetic room including safety and risk, prepping and draping in today's theatres and medical devices: safety, security, sterility and risk.

Assessing and responding to patient risk

- We saw risks such as underlying conditions and diseases a patient may have were identified during pre-operative assessments. The risks were usually identified at initial assessment and then again on day of admission to identify any changes in a person's condition that may pose added risks. Risks and how they were to be managed were discussed with the patient and detailed in the medical and nursing notes.
- A risk assessment document was completed for all inpatients that included pain, nutrition, manual handling, bed rails and pressure ulcer risk. We saw these had been completed in 12 of the 13 patient care records we reviewed.
- All the ward and departments used a national early warning score (NEWS) chart. This helped staff recognise

when a patient's condition was deteriorating and when to seek further help and support from doctors. We saw these had been completed for the patients whose care notes we reviewed and had been escalated to appropriate staff as necessary.

- We saw a Situation, Background, Assessment, Recommendation (SBAR) form in use in some departments and wards. SBAR is a recognised communication tool to ensure that appropriate information is handed over verbally and an adequate response is received.
- We observed a Five Steps to Safer Surgery checklist being completed in the operating theatre prior to commencement of the operation. It was clear there was a member of staff in charge of the checklist. All staff were fully engaged in the process.
- We observed the anaesthetic checklist being completed in the anaesthetic room prior to a patient being anaesthetised. Two members of staff checked with the patient their details, the pre-operative assessment, what operation they were expecting to have and that the site had been marked correctly.
- If a patient was assessed as requiring a stay in the intensive care unit (ICU) post-operatively staff would only carry out the procedure if they were sure a bed was booked in the ICU. Some patients had a planned extended stay in the recovery area if it was assessed they may need longer to recover because of other medical conditions they may have. Some staff who worked in recovery had critical care training and experience and were confident the department had the skills to look after high dependant patients in the recovery area.
- There was access to surgeons or members of their team for surgical patients and to medical teams for medical patients on surgical wards 24 hours a day.

Nursing staffing

- We saw there were nurse handovers at shift change times. In most cases the handovers included an up to date safety brief.
- We saw, on some wards, they had 'actual' staff versus 'planned' staff (based on registered nurse safer staffing guidelines produced by NICE in July 2104) displayed for staff and visitors to see. On the Trauma Ward for example on 4 June 2015 nurses planned for the morning shift were eight, with seven actually on duty, for the afternoon/late shift eight were planned and eight were on duty and overnight four were planned and four were on duty. The safer staffing tool the trust used by the trust, based on registered nurse safer staffing guidelines, showed that in April 2015 three of the five surgical wards were "staffed as planned" and the other two were "assessed on a daily basis" and where there were shortfalls staff "worked flexibly to meet patient's needs". The document we reviewed did not take into account the Surgical Assessment Lounge, Theatre Direct or the operating theatres and recovery.
- We were told and saw there were a mix of experienced and recently qualified staff with a range of skills and specialist interests to meet patient's needs. Staff told us at times they were short staffed and were often asked to change shifts or move to cover other surgical wards. They added they liked to help where they could as they wanted to provide a good service.
- Staff told us they used bank and agency staff who had worked on the ward or department before when possible. They said, especially in the operating theatre environment, that staff who knew about the subject were really valuable.
- We were told there had been a successful trial of four staff based in each theatre per list instead of three, which included a porter. We were told this had improved the flow through the theatres and helped to keep lists running on time.
- We were told recruitment was ongoing. The matron in Trelawney Wing theatres told us they had twelve whole time equivalent vacancies, but they had recruited eight new staff to these posts. Four new to the trust, two from elsewhere in the trust and two newly qualified staff. Staff throughout the surgical division told us they thought staffing levels were improving but retention of staff seemed to be a problem. Staff felt retention was difficult because staff were working so hard they felt they could not do their jobs properly.

Surgical staffing

- Each surgical speciality had their own team of specialist consultants. In September 2013 the trust had a higher proportion of consultants (46%) compared with the England average of 40%. There were slightly more middle grade doctors (12%) than the England average of 11% but there were less registrars (24%) than the England average of 37%. Junior doctors made up 17% of the workforce compared to the 13% England average.

Registrars and junior doctors told us they knew recruitment was ongoing and that they currently felt overworked and sometimes unsupported by consultants.

- There was 24 hour seven day a week access to registrars, middle grade and junior doctors. Consultants were available for operating lists, some ward rounds and on call support overnight and at weekends. Junior doctors said they had access to senior support when required.
- Handovers took place twice a day on the inpatient surgical wards.
- Locum doctor cover was used when necessary and they were often staff that had worked at the trust before and therefore familiar with trust procedures.

Major incident awareness and training

- There were two operating theatres in Trelawney Wing designated as emergency theatres and used seven days a week 24 hours a day. There were plans in place to allow for fluctuations in demand due to the holiday season and winter pressures. T they included cancelling of elective surgery where a patient required a bed. The staff would place some patients on standby at home and call them in for their procedure if a bed became available. Staff told us patients understood and were happier staying at home to wait for a bed than travelling to the hospital just in case.
- There was a major incident room equipped with items and documentation that may be needed if a major incident was declared.

Are surgery services effective?

Are surgery services caring?

Are surgery services responsive?

Requires improvement

Surgical services require improvement in some areas. A high number of patients needing elective surgery requiring an inpatient bed were having their operations cancelled. This was mostly due to medical patients being admitted to designated surgical beds because there were no medical beds available in the hospital.

These patients were not always being offered a new date for their operation within 28 days of their operation being cancelled. Those patients requiring day surgery were rarely cancelled.

The trust were exploring ways of increasing capacity for surgery at their other hospital sites to relieve pressure on the surgical beds at the Royal Cornwall Hospital.

Patients with learning difficulties, dementia or mental health issues were looked after by staff trained to deal with their specific needs.

Service planning and delivery to meet the needs of local people

- The surgical division provided general, specialist and emergency surgery to the population of Cornwall and the Isles of Scilly. They also provided day surgery at their other sites at St Michaels Hospital in Hayle and West Cornwall Hospital in Penzance. Orthopaedic surgery and breast surgery requiring an inpatient stay were provided at St Michaels Hospital.
- The trust were reviewing the use of St Michaels Hospital operating theatres to ensure that the hospital was being used to maximum effect as it had been identified there was capacity to provide more inpatient surgery than was currently being delivered. More ear nose and throat and oral surgery was already taking place at St Michaels Hospital. Initiatives such as this could help to improve the flow at the Royal Cornwall Hospital and meant some patients could have their elective surgery nearer to home**.** There was a criteria in place for patient's who could have their surgery at St Michaels hospital due to the non 24 hour medical cover provided. Each ward and department had escalation plans for when there was lack of capacity and increased demand for their services. A 24-hour clinical site team had an overall view of capacity and emergencies within the hospital. Bed meetings were held four times a day to establish where there were any available beds in the hospital with the aim of cancelling as few patients as possible
- The surgical wards and day surgery unit (Theatre Direct) had designated male and female bays and a range of single rooms. There were separate male and female toilet and bathroom facilities.
- The orthopaedic surgery teams were planning to extend their operating day in order to carry out more elective

orthopaedic operations and reduce the number of cancellations. This was to be a three month pilot at the end of which the activity would be measured to identify if a reduction in cancelled operations had taken place.

- The hospital had been escalated to "black" status a number of times between December 2014 and March 2105. Levels of escalation from green to red to black are based on the hospitals ability to meet the A&E national targets to see and admit patients. When there are high numbers of patients in the emergency department (ED), very few available beds in the hospital and the number of patients having to wait for longer than four hours in the ED was rising this had triggered black escalation. An impact of this was felt in the trusts ability to continue with elective surgical activity as many medical patients had been admitted to surgical wards due to the lack of beds in the medical wards. The trust had a protocol of cancelling elective surgery where safe to do so, increasing the number of ward rounds by medical and surgical teams to assess which patients were fit for discharge and increasing bed meetings to make sure managers were aware of available bed numbers at all times.

Meeting people's individual needs

- All wards we visited had a mixture of 6 bedded bays and single rooms. Theatre Direct had single rooms and separate male and female lounges with beds and/or chairs for use whilst patients were recovering from surgery.
- Patients with complex needs requiring surgery were assessed by the appropriate surgery team and medical team if necessary. A plan was developed with the patient. If required a bed would be booked on the critical care unit for immediate post-operative recovery.
- Translation services were available via a telephone service. Advice leaflets could be provided in other formats such as large print. The leaflets could be translated into other languages on request.
- Access to the operating theatres and the surgical wards was by means of stairs or a passenger lift with level access at department/ward entrances. Disabled toilets were available in all the ward areas.
- In the operating theatres patients with learning difficulties were usually first on the list to reduce the anxiety for the patient. Staff told us they contacted the learning disability team for advice when they were aware of a patient with learning difficulties needing pre-operative assessment, an operation and post-operative inpatient care. They said the team were really helpful and supportive. Staff said 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. There was a dedicated dental operating list for patients with learning difficulties.
- There was access to mental health advice and support for the operating theatre and ward staff when they were providing care and support to people with mental health issues.
- We saw there were dementia link nurses on the surgical wards. They attended regular link meetings where they were updated about current best practice and guidance. Staff who worked on surgical wards with medical outliers said they felt they had the skills to manage patients with a form of dementia.
- 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 patients have with staff may have an impact on a patients wellbeing. The outcomes were shared with staff and formed part of future learning and development plans.

Access and flow

- 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 trust had implemented a 'standby' list where patients stayed at home until it was confirmed there was a bed available for them. They were then contacted to come into the ward. This meant patients did not have the anxiety of arriving at the hospital just to be told their operation had been cancelled.

- Data received from the trust indicated that in for the period of April – June 2015 there were 5239 planned elective operations. Of these 284 (5.42%) had been cancelled with 69 of these being cancelled on the planned day for surgery. This was a reduction from 108 in February 2015, 119 in January 2015 and 165 in December 2014.
- 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.
- The trust were working to increase the day surgery activity at St Michaels Hospital to reduce cancellations and enable day surgery at the Royal Cornwall Hospital to be maintained at a good level. We were told the pre admission pathway had been improved to increase efficiency prior to admission. And the booking service had improved which had also had an impact of improving the process for patients meaning they often did not have to wait so long for appointments.
- Emergency surgery was carried out seven days a week 24 hours a day. There were emergency surgery teams on standby overnight in the hospital and staff on call at home should they need more support of advice.
- Referral to treatment times which require 90% of patients to start consultant led treatment within 18 weeks of referral between April 2013 and November 2014 met standards in ear, nose and throat (91.8%), urology (92.0%), oral surgery (91.3%), cardiothoracic surgery (100.0%) and thoracic medicine (100%). Areas where the target was not been met were general surgery (88.4%), trauma and orthopaedics (88.6%) and ophthalmology (89.8%).
- Colorectal surgery patients had a short length of stay as enhanced recovery programme was in use. The patients had telephone contact with the specialist nurse once at home. They then attended the hospital to see the consultant or specialist nurse in St Mawes Lounge or Theatre Direct for review.
- The trust told us they were up to date with their data submission to the National Hip Fracture database. The latest report available relating to 2013 showed the trust submitted 601 cases for review. Once a patient, who had an overnight stay, after surgery was ready for a routine discharge they were discharged home quickly. We were told length of stay was reduced when enhanced recovery pathways (**enhanced recovery is an evidence-based approach that helps people recover more quickly after having major surgery)** were in use. We did not have any data to support this perception. If a patient's discharge was more complex and required a package of care setting up at home discharge could be delayed until the resources were in place. These patients would be discussed at regular multi-disciplinary meetings which included discharge co-ordinators. Information received from the trust showed that were 9 reportable delays in discharge, across the surgical wards at the Royal Cornwall Hospital, on 2 and 3 June 2015, eight on 4 June and 12 on 5 June. The reasons for the delay included waiting for a bed in a community hospital, awaiting assessment by an occupational or physiotherapist and other health care professionals and awaiting a domiciliary care package.
- Patients requiring day surgery were admitted to the Theatre Direct or the Surgical Admission Lounge. From there they went directly to the operating theatre, recovered returned to the unit to complete their recovery and were then discharged home.
- Ward staff told us they found the medical teams responded to their requests to review medical patients on surgical wards (medical outliers) and visited the patients on a daily basis. Staff added that it was often more difficult to get speciality surgical patients outlying on general surgical wards seen by their specialist surgery team. This led to staff spending time trying to contact the relevant teams and sometimes delayed discharges as a result.
- The surgical emergency ward (St Mawes) had a triage area (St Mawes Lounge) with seating and two consultation rooms. This provided assessment to ambulant patients referred mainly via their general practitioner (GP). It was staffed with one junior doctor, a staff nurse and a health care assistant. Ultra sound

scans were available in St Mawes Lounge Monday to Friday. Patients were either assessed as requiring admission to one of the surgical wards or could be discharged home with some advice and if required be added to the elective surgery list for an operation in the future. The service had received good feedback from patients who had used it.

Learning from complaints and concerns

- Information was displayed on the wards to explain how patients could raise concerns or complaints.
- Staff we spoke with were all aware of the complaints process. Staff told us that they would try to resolve any issues immediately. If issues could not be resolved, the patients were directed to the complaints process and/or the Patient Advice and Liaison Service (PALs) who could help patients and their families who wanted to make a formal complaint. Staff were aware of any complaints that had been made about their own ward or department and any learning that had resulted from them. Complaints received at the time of the inspection were mostly related to cancellation of elective surgery.
- Between January 2015 and March 2015 there were no trends identified in the concerns raised for theatres and anaesthetics. There were four complaints relating to anaesthetics and theatres in this time. There were a further 16 concerns related to anaesthetics and theatres that were included in complaints raised in other divisions, 12 were related to anaesthetics and four to theatre and recovery. They were all investigated using the trusts complaints policy. Any required actions as a result of investigations were shared with the relevant teams and an action plan created with end dates to check for compliance and evidence of shared learning.
- Between January 2015 and March 2015 (quarter 4) the surgery, trauma and orthopaedics division received 44 complaints. This was an increase on 10% on the last quarter but a decrease of 23% compared the same quarter in the previous year. For the same period there were 142 concerns which included complaints received about other divisions but where the issues relating to surgery, trauma and orthopaedics. The highest proportion were about trauma and orthopaedics (56), followed by urology (29) and ear, nose and throat (27). Issues included delay in treatment, waiting too long for treatment and staff attitude. There were eight learning actions identified in quarter 4: seven were to give feedback to staff as groups or individuals and one was around improvements to documentation. The information we had from the trust included reminding staff that an action plan had to be completed for any issues that were upheld following a complaint investigation.
- 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. Staff told us this would then be discussed at ward/unit and department meetings and/or safety brief meetings to ensure staff were aware of how to implement the changes and why.

Are surgery services well-led?

Critical care

Safe	
Effective	
Caring	
Responsive	Requires improvement
Well-led	
Overall	Good

Information about the service

The critical care department includes the intensive therapy unit (ITU) and high dependency unit (HDU). There are 15 beds; however the unit space is configured for 19 beds. The department provides beds for adults and for children. The dependency of patients varies between level one and level three with level three being the higher level of care and support needs.

In the year to March 2015, 37 paediatric patients were admitted to the critical care unit. There were 5.44 Whole Time Equivalent (WTE) nursing staff to provide care for those patients.

A critical outreach team of four full time staff are available seven days a week 12 hours a day to assist with the care of critically ill patients throughout the hospital. There is consultant doctor cover available in the critical care unit 24 hours a day.

We spoke with six medical staff including the staff from the outreach team and one administrative staff. We requested and reviewed performance information about the trust.

Summary of findings

The critical care unit was not responsive to patients admitted to the unit. The pressures of bed capacity throughout the hospital impacted on the flow of patients through the unit. There were delays to some discharges to the wider hospital and some delays for patients with planned admissions to the critical care unit. Delays in discharging patients who are well enough to leave the critical care units can impact on their recovery, equally delays in being admitted to the critical care unit may impact on patients being able to receive care and treatment in the most appropriate environment to meet their needs.

The management of technology in the department continues to require sufficient staff have the advanced skills to manage the system in the future. This is an ongoing piece of work for the trust.

The increase in outreach staff available was responsive to the needs of the unit and the wider hospital.

Critical care

Are critical care services safe?

Are critical care services effective?

Are critical care services caring?

Are critical care services responsive?

Requires improvement

The critical care unit was not responsive to patients admitted to the unit. The pressures of bed capacity throughout the hospital impacted on the flow of patients through the unit. There were delays to some discharges to the wider hospital and some delays for patients with planned admissions to the critical care unit. These delays would adversely affect outcomes for patients.

The management of technology in the department continued to require sufficient staff with the advanced skills to manage the system. This is an ongoing piece of work for the trust.

The increase in outreach staff available was responsive to the needs of the unit and the wider hospital.

Service planning and delivery to meet the needs of local people

- In the year April 2014 to March 2015 the critical care unit provided care for1071 patients who were assessed as between level 1-3 dependency. 197 of those were planned admissions, 14 were transfers from other hospitals and there were 29 transfers to other hospitals. There were 35 readmissions to the unit during the patients same period of hospital admission.
- The trust provided15 critical care beds in total. Adult critical care bed occupancy reached 100% in February and April 2014, otherwise the bed occupancy fluctuated around the England average. We attended a critical care team meeting when planning for staffing levels and summer pressures was discussed.
- There were systems in place to allocate appropriately trained staff to take paediatric admissions in the critical care unit. The electronic system could track the paediatric journey through the hospital from ED to paediatric ED to the critical care unit (CCU). One staff member spent 50% of their time in the children's high dependency unit and 50% of time in the CCU, so provided paediatric skills to the unit. 26% of critical care staff had a paediatric qualification. Further staff training was planned.
- We had concerns about technology management in critical care. The critical care department maintained all patient records on a computer system. One staff member was key to making changes and adaptations and working with system problems identified by staff. The action plan provided by the trust identified that there was a support contact in place for the IT system. We found that the one staff member remained the only staff member with advanced skills with the system. The Operational Head of the unit was aware that this exposed the unit to risk and had raised concerns about this. The trust was currently trying to ensure new cover to support the unit in case this was needed.
- We saw that there were two rooms available for relatives to use that provided privacy and separate areas for discussions.
- Relatives access to the unit was well managed. Visitors to the unit had to use an intercom to gain access. This was seen to be done promptly and visitors welcomed. For patients who had been on the ward a long time, plans were in place to develop access to outdoors and enable pets to visit.

Access and flow

- The trust contributed their data to the Intensive Care National Audit and Research Centre (ICNARC) so they could be evaluated against similar departments nationally. The unit performed within expectations for all but three of the measures in the 2013/2014 ICNARC. The audit identified the unit was performing above expectations for two of the three hospital mortality indicators and below expectations for out of hours discharges to the wards. This had been previously identified at inspection in 2013. We saw that one patient had been transferred in the night during our inspection. All night time discharges and transfers were recorded and in the last year there were 66 discharges from the unit after 12 midnight.
- The lack of available beds in the hospital affected the flow of patients out of critical care. Some discharges remained not at the optimum time and were delayed. All delayed admissions to the wards of over four hours

were recorded on the electronic incident reporting system. The Core Standards for Intensive Care Units (2013) identifies that discharge from an intensive care unit should be within four hours of the decision being made and there should not be any non clinical reason preventing the move. In April 2015, 30 patients were treated in the critical care unit and had a delayed discharge. In the last year to March 2015, 619 patients were delayed over four hours for discharge. At the time of our inspection three patients were identified as having a delayed discharge. All three of those patients had been waiting over 24 hours for discharge to another ward, with one being over 48 hours. The hospital bed meeting identified the three critical care patients waiting to be transferred to wards, no identified action was seen to be taken. At the point of delayed discharge the consideration must be that the patients were in shared sex accommodation and so in breach of the mixed sex standard.

- The trust risk register recorded a rating of concern about clinically critical elective patient's post operatively being at risk of not being treated within a critical care bed or their elective surgery cancelled. Patient's post-surgery who required a critical care bed remained in recovery until a bed became available. Elective patients were reviewed and cancelled when critical care beds were unavailable.

Meeting people's individual needs

- 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. The trust action plan had not been updated to accurately reflect changes taken place. We found that there were now four full time outreach staff covering 12 hours a day seven days a week. Staff on the wards told us the outreach staff were accessible and available to attend wards and support unwell patients. We saw that outreach staff attended bed meetings to brief the bed management team on the location and health of unwell patients in their care. There was a plan in place to increase the outreach cover to seven days a week.
- A small handover of information took place at the patient's bedside when staff shifts changed. The overarching handover of patient information took place in a room away from the patient area to reduce the risk of being overheard and patient privacy being compromised.
- The care plan for each patient was reviewed on admission and would be expanded as further treatment was provided and monitoring commenced. The electronic recording system in place enabled staff to view the patient's vital signs and were charted every ten minutes, this could depending on the settings, then slow down the frequency to hourly. The same system enabled the recording of infusions and medicines prescribed. The fluid balance was automatically calculated. All pressure area care provided was recorded within the same system.
- We saw that when a young person was admitted they were cared for in a bay separate to the rest of the unit and a family member was able to stay with them.
- Patients and visitors who had a physical disability had access to the unit. Lifts and level access were available.
- Patients who were vulnerable or lacked capacity to make a decision were supported by nursing staff. Nursing documentation included areas of consent to be considered. Care records included a section for staff to complete to record they had considered consent and how decisions relating to consent had been made.
- Translation services were available through the switchboard and via a direct call to the language help line available to the unit. We had previously identified that information management for relatives could be improved. Information available to relatives was seen to be available and appropriate.
- We saw that 14 staff on the critical care unit had received dementia awareness training.

Learning from complaints and concerns

- The critical care department captured patient comments and feedback. This included any complaints made about them. We were not aware of any complaints or referral to the Parliamentary Ombudsman for critical care.
- Staff told us that complaints and outcomes were cascaded to staff through the team brief and via staff intranet.
- We observed that if staff were not careful about switching off the intercom to the outside corridor nurses station conversations could be heard by anybody stood outside the ward. We overheard a conversation whilst

awaiting admission to the unit. This was a risk to patient confidentiality. We expressed our immediate concerns and action was taken to address the risk. Facilities were contacted immediately to change the system in place

Are critical care services well-led?

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 patients 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 hospital 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.

Action the hospital SHOULD take to improve

- There are adequate infection control procedures and equipment in the emergency department.

Outstanding practice and areas for improvement

- A regime for the cleaning staff to follow in the emergency department, including a system that demonstrates when tasks have been completed, is introduced.
- All medicines are stored correctly.
- Systems to improve the reporting, monitoring and learning from incidents, complaints and risks in the emergency department are reviewed.
- Arrangements for when medically expected patients are admitted through the emergency department are reviewed to reduce the impact on the department's ability to manage and treat emergency patients.
- All staff in the emergency department are aware of the guidance and protocols to ensure the National Early Warning Score is fully understood and followed as required.
- The treatment plan for patients receiving opiate pain relief is clear and supports those patients' specific needs.
- Areas of the environment are inadequate and suitable for patient use, particularly the stroke unit and the changing facilities in the Coronary Investigations Unit.
- There are sufficient staff with the right skills to enable ongoing management of the IT systems in critical care where currently there is a reliance on single members of staff.
- Where lockable notes trolleys are provided they are locked when unattended.
- Resuscitation trolleys are checked as required on either a daily or weekly basis according to trust policy.
- Hand hygiene dispensers are sited so as to be obvious to patients and staff and their regular use is encouraged.
- Review of outlying specialist surgical patients on general surgical wards is carried out more effectively to prevent delays in some patient discharges.

All required staff attend level 1 and 2 adult safeguarding training as part of their ongoing mandatory training programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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. 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. 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. A number of records in the emergency department were found to be incomplete, with omissions primarily relating to allergy information and fluid administration. 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. 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.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

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.

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.

This section is primarily information for the provider

Requirement notices

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 of 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 were having difficulty locating replacements.

This section is primarily information for the provider

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **18.-(1) Sufficient number of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirement of this Part.** • 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 department.