Care Quality Commission

Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospital

Inspection report

Treliske
Priory Road
Truro
TR1 3LJ
Tel: 01872250000
www.royalcornwall.nhs.uk

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Ratings

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

Our findings

Overall summary of services at Royal Cornwall Hospital

Inspected but not rated

Inspected but not rated

Royal Cornwall Hospitals NHS Trust (RCHT) is the main provider of acute hospital and specialist services for most of the population of Cornwall and the Isles of Scilly, 587,000 people. The trust delivers care from three main sites – Royal Cornwall Hospital in Truro, St Michael's Hospital in Hayle and West Cornwall Hospital in Penzance.

We inspected some of the medical wards at Royal Cornwall Hospital based on concerns we had received. This was a focused inspection where we looked at some aspects of safe, effective, caring, responsive and well led.

During the inspection three medical wards were closed due to COVID-19 and we were not able to visit these. This had also resulted in the loss of 20 empty beds as the trust was not able to place patients on these wards who did not have COVID-19.

We previously inspected medical care as part of our urgent and emergency care reviews in March 2022. At the inspection in March 2022, the trust was under significant pressure for their services which had resulted in long waits for all patients in the Emergency Department (ED). Once the decision to admit medical patients had been made in the ED, patients often had to wait a long time for admission to the Acute Medical Unit (AMU) and then on to wards which resulted in delays with their treatment. At this inspection we found the situation had not improved. Medical patients were still waiting in the emergency department for long periods for transfer to the acute medical unit. Whilst this is unacceptable, the trust had some new initiatives to reduce waiting times, which were due to start following our inspection. For example, a frailty unit was due to open by the end of October 2022.

Summary of CQC findings on medical services at Royal Cornwall Hospital.

Staff assessed risks to patients and acted on them. They managed medicines well.

Staff gave patients enough to eat and drink. Staff worked well together for the benefit of patients. Restrictions to patients' liberty were implemented to maintain their safety.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.

The service planned care to meet the needs of local people and took account of patients' individual needs.

Staff were focused on the needs of patients receiving care.

However:

Our findings

The service did not always have enough staff to care for patients and keep them safe. Staff were offered training in key skills, but due to pressures on the service, they did not always have time to complete it. Not all records relating to patients' care had been completed in full.

When capacity within services was under pressure, areas were used that were not always suitable for patients and lacked some facilities. Some wards did not meet the needs of patients living with dementia and were tired in appearance.

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Not all system partners supported the trust when patients were inappropriately placed.

Not all ward leaders had the skills to run the service as they were new in post. Morale was low for some staff in the service due to the significant and unrelenting pressures which had been ongoing for a long time and staff shortages.

Medical care (including older people's care)

Inspected but not rated

Is the service safe?

Inspected but not rated

Inspected but not rated

Mandatory Training

The service provided mandatory training in key skills to all staff, but the pressures to maintain staffing levels meant not all staff completed their training in a timely manner.

Staff did not always keep up to date with their mandatory training. Registered nurse mandatory training compliance for specialist medicine was 83% and health care assistant (HCA) compliance rate was 80%. Below the trust target of 90%.

On Tintagel ward, registered nurse mandatory training compliance rate was 69% and health care assistant compliance rate was 57%. Staff on Tintagel ward said they did not have allocated time to complete their mandatory training due to the pressures on the ward. Some staff told us they tried to do it in their own time. The ward was also below the trust target of 90%. Senior staff on the ward were aware they were below trust targets and they were looking at ways to address this with staff.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This included recording physical observations; for example, blood pressure, pulse and respirations. This information was recorded and stored electronically and calculated the national early warning score (NEWS2). NEWS2 is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside. Its purpose is to identify acutely ill patients, including those with sepsis, in hospitals in England. Staff told us they knew when they had to call for a medical review. The four patient NEWS2 charts we reviewed were complete and acted upon.

We saw in one set of patient notes they had several episodes of hypoglycaemia (low blood sugar) due to the medication they were taking. Staff had used a sticker in their notes which detailed the blood glucose reading and provided actions for staff to take. We saw evidence of the action taken and the patient’s blood glucose level following staff intervention. A member of staff told us they monitored the patient's blood sugar readings frequently to look for signs of hypoglycaemia.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff showed us these risk assessments on the handheld electronic devices they used. They told us they updated risk assessments frequently, following any changes in condition and the system used for recording these also indicated to staff when they needed to be update. Staff knew about and dealt with any specific risk issues. We reviewed four patients notes and saw SSKIN bundle assessments, comfort rounding, bedrail assessments and falls assessments completed. SSKIN stands for S – surface. S – skin inspection, K – keep moving, I – incontinence, N –

nutrition and hydration. The SSKIN bundle has been identified as a key process/intervention in pressure ulcer prevention. Staff had access to pressure relieving equipment for patients assessed as being at risk. Staff told us they also changed patients position frequently throughout the day and night if they were not able to move themselves for their comfort.

Patients at high risk of falls were cared for in a bay near to the nurse's station with staff present in the bay all the time. We saw a post falls checklist completed in patient notes following a fall.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Mental health support was provided by another NHS trust. We observed in one patient's records evidence of a mental health review on admission to hospital and ongoing support.

Staff shared key information to keep patients safe when handing over their care to others.

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

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix when able and through the safe care process held twice daily.

The service did not have enough nursing and support staff to keep patients safe. Staff told us on one of the wards we visited they were often short staffed. Senior staff told us they were continuing to advertise vacant posts for registered nurses and health care assistants and were recruiting nurses internationally. Senior staff told us they were looking at a blended workforce and developing their current staff progression pathways such as the trainee nursing associate pathway. One ward had a 33% vacancy rate in June 2022 and only had the required number of staff on duty for two days from 1 June 2022 to 30 September 2022. The same ward was short of three health care assistants (HCAs) on the day we inspected, whilst we were present on the ward, some additional care staff were sent to help.

The number of nurses and healthcare assistants did not match the planned numbers. We saw the planned and actual numbers on display outside each of the wards we visited, we found that not all of these had the required number of staff. The trust sent us after the inspection information about planned versus actual numbers for their medical wards. This demonstrated bank and agency staff were used to increase staff numbers and most wards did not always meet the required numbers.

Heads of Nursing calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior nurses on the ward were being trained to use the safer care nursing tool to assist with the calculation of nursing requirements. Each ward had to input into the safer staffing tool three times per day. Meetings were held with senior staff across the trust to find out where the most need for staff was. Staff could then be allocated to other wards to help.

The ward manager could not always adjust staffing levels daily according to the needs of patients. This was dependent on the staffing levels throughout the medical wards.

Medical care (including older people's care)

The combined medical services vacancy rates for qualified nurses was 7.7%. For health care assistants (HCA) it was 20%. The trust had recruited oversees qualified nurses to fill posts. Recruitment for HCA was ongoing at the time of our inspection. On Tintagel ward they had recruited five HCA who were due to commence work shortly.

Sickness rates across the medical wards from June to August 2022 was above the trust target of 3.75%. Each ward had varying amounts of sickness each month and all above the trust target. COVID-19 had impacted on the sickness levels on the medical wards.

At a previous inspection in 2019 we issued a requirement notice for staffing due to shortages. However, as this is now a national problem with recruiting qualified nurses and health care assistants the trust has been looking at several initiatives to address this problem. For example, international recruitment of qualified nurses and assistance with finding accommodation in Cornwall. Whilst the trust has made some improvements with recruitment further improvements will be required to reduce short staffing.

Medical staffing

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

The service mostly had enough medical staff to keep patients safe for most of the time. We were sent numbers of medical staff for each speciality following the inspection. However, the numbers altered each day and so it was not clear all the required medical staff were on duty at the allocated times.

Some medical staff felt due to the pressures on their services, not all patients were able to be placed on the ward that specialised in their medical condition and they felt wards had lost some of their speciality focus. Some medical staff took extra time trying to find their patients for ward rounds which they felt impacted on longer hospital stays due to delays in treatment starting.

Not all patients were able to be seen on regular wards rounds and reviewed by consultants who specialised in their medical condition. For example, on Tintagel ward neurology consultants were only able to undertake twice weekly ward rounds due to the limited number of these consultants. In between these times the eldercare consultants reviewed neurology patients but were not able to provide neurology treatment plans. Staff told us they could contact the neurology consultant by telephone for advice and support about patients.

Sickness rates for medical staff varied between the medical specialities with some having higher sickness rates than others. For example, the trust sent us details about sickness rates, and it was just over 13% for endocrinology at the time of the inspection for junior medical staff.

Support was provided for junior medical staff out of hours. The service always had a consultant on call during evenings and weekends. Therefore, junior medical staff could contact them for advice and support.

At a previous inspection in 2019, we issued a requirement notice about consultant shortages and the need for the trust to recruit to the vacant posts. Senior staff at the trust told us they often had issues recruiting to some specialities for example, neurology and were constantly trying to fill these posts. Whilst the trust has made some improvements with recruitment further improvements will be required to fill vacant consultant posts.

Records

Medical care (including older people's care)

Staff mostly kept detailed records of patients' care and treatment. Records were clear, stored securely mostly up to date and easily available to all staff providing care. Not all staff had signed and dated their entries.

Patient notes were comprehensive and all staff could access them easily. We reviewed four sets of patient notes, some notes were difficult to read, and some entries were not always signed and dated. This meant it would be difficult to follow up on any issues if the member of staff was unknown.

Not all records were completed in full for example, food and fluid charts. Staff were not always completing patients' fluid and nutrition charts where needed. This meant staff could not accurately monitor patients input and output.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff told us patients records were transferred at the same time as the patient. We saw hand over forms for patients when their care was transferred to another team. However, we also found these were often not dated or signed by the member of staff completing them.

Records were stored securely. Paper records on wards were kept in locked trolleys. Staff were observed to be careful to maintain confidentiality of paper records.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Ward-based clinical pharmacy advice was available during weekdays. An on-call pharmacist was available outside of core working hours. Staff were well informed of this and knew the routes to contact pharmacy.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Medicines were clinically reviewed by a ward-based pharmacy team. Pharmacists were available to speak to doctors, nurses and patients for advice and support.

Workforce challenges within pharmacy meant that pharmacists and pharmacy technicians were not always available to offer ward-based support. Pharmacy teams used a dashboard tool to identify patients prescribed high-risk medicines, those newly admitted to the ward or ready for discharge. This meant that pharmacy activity could be focussed on patients with the highest need.

All patients we checked had an assessment for venous thromboembolism (VTE) and were prescribed a prophylactic medicine when appropriate.

Pharmacy advice and guidelines were available to support prescribing and administration decisions. For example, whether medicines were suitable to be administered to patients through feeding tubes.

Information about medicines was available in a range of formats, for example large print, easy read, very easy read, different languages.

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

Medical care (including older people's care)

Controlled drugs were stored securely and recorded appropriately.

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

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

Staff followed current national practice to check patients had the correct medicines. Pharmacists had input into medicines reconciliation in line with national guidance. A range of different information sources were used to make sure patients were prescribed the right medicines.

Implementing one EPMA system across NHS trusts and hospices in Cornwall had made it easier to see what medicines were prescribed.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The Trust continued to alert staff to risks associated with medicines. An audit programme measured whether wards were following trust medicines and prescribing policies. Outcomes were identified and action plans for improvement where necessary, were in place at ward level.

Staff knew how to report medicines incidents or near misses via the trust's electronic reporting system. Staff we spoke with felt confident in raising a medicines incident should they need to. The trust medicines safety officer shared learning around medicines incidents.

Decision making processes were used to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The pharmacist reviewed prescribing of all medicines that might be used to control patient's behaviour and contributed to care plans to reduce their further use.

Is the service effective?

Inspected but not rated

Inspected but not rated

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Nursing staff supported patients who needed assistance to eat and drink. We observed staff supporting patients at mealtimes and all staff on the ward were involved at mealtimes.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw staff had access to this tool on the handheld devices. Patients were given a score depending on the risk of malnutrition and guidance was provided for staff to follow on what actions to take.

Medical care (including older people's care)

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. We saw evidence in the patients records we examined of dietician input for those patients who were deemed a high risk of malnutrition. We also saw one patient had been reviewed by the speech and language therapists following a stroke as this had affected their swallowing.

Competent staff

The service provided training to make sure staff were competent for their roles, but not all staff had completed these.

Staff were mostly experienced, qualified and had some of the right skills and knowledge to meet the needs of patients. On Tintagel ward we asked to see details of the competence assessment of qualified nurses following some information we had received. This showed most of them were up to date with their competency assessments. However, some of the new international nurses had not completed several assessments. This was due to some waiting for their Nursing Midwifery Council (NMC) pin number to be able to practise as a nurse and the limited time they had been on the ward. We were sent a copy of a new starter form staff had to complete within the first two weeks of their supernumerary time. We did not meet any new staff during the inspection to confirm this, but one member of staff confirmed they did have an induction period.

Clinical educators supported the learning and development needs of staff. Staff told us that there was a Learning and Development team who helped with the training of staff on the wards.

Ward leaders made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us that they were kept up to date with new information via emails if they were unable to attend meetings.

Ward leaders identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. However, staff told us that it was difficult to get the time to complete their mandatory and other training as the ward was busy and often short staffed.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw in the records of one patient they had support from the learning disabilities team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Medical care (including older people's care)

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. We saw in some of the patients records we examined where staff had documented a decision was made in the best interest of the patient. One patient had also had two best interest meetings to discuss their plans for discharge.

Ward leaders monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. We saw two patients had Deprivation of Liberty safeguards in place. Both had expired but senior staff told us the local council was behind with their reviews and updating of these safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Inspected but not rated

Inspected but not rated

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. We observed staff assisting patients to mobilise to the toilet and orientating them to the areas of the ward.

Patients said staff treated them well and with kindness. The inpatient and day case survey responses from 12 patients from 1 July 2022 to 30 September 2022 rated Tintagel ward as 'very good' (eight patients) and 'good' (four patients). All the 12 patients surveyed said that staff showed care and compassion.

We observed for one patient who had a one to one member of staff that they had limited interaction with the patient and did not appear to engage with them in any activity.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff interacting with a patient who was trying to leave the ward who was subject to a Deprivation of Liberty safeguard, they de-escalated the situation and treated the patient with dignity and respect.

Understanding and involvement of patients and those close to them

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

Medical care (including older people's care)

Staff made sure patients and those close to them understood their care and treatment. We had received feedback prior to the inspection that not all families were kept up to date on their relative's condition or treatment whilst on Tintagel ward. We did not see any relatives during our inspection. However, communication with patient's families about their treatment and care was clearly documented in patients notes with a yellow sticker so that this was easy to find in their records.

The inpatient and day case survey responses from 12 patients from 1 July 2022 to 30 September 2022 for Tintagel ward showed that in nine out of the 12 responses, patients said they had enough time to discuss their health or medical problem with a healthcare professional.

Staff spoke with patients in a way they could understand. The survey also demonstrated in all 12 responses; things were explained in a way patients could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service.

Is the service responsive?

Inspected but not rated

Inspected but not rated

Meeting people's individual needs

The trust took account of patients' individual needs and preferences. Staff coordinated care with other services and providers, but this was not a quick process and not all patients required hospital treatment and support. Due to increased capacity pressures on their services and their bed availability, not all patients were cared for on a ward that treated patients with the same speciality. Some patients were not reviewed in a timely manner.

Due to pressures on capacity and bed availability, some patients were cared for on a medical ward or in escalation areas which did not specialise in their medical condition. We spoke with a consultant who told us they had 18 patients on five different wards and trying to review all of them took additional time and felt this increased their length of stay.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us they were able to obtain advice and support from specialist nurses if required in relation to dementia, learning disabilities and mental health. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw one 'this is me' document that was partially completed. The learning disability team were involved in the care of a patient on Tintagel ward.

Some wards were not all designed to meet the needs of patients living with dementia. We visited Tintagel ward which specialised in older people and neurology. The ward was not colour coded, for example to help patients living with dementia find their way around like other older people wards in the hospital. The ward also had no designated area for patients living with dementia to have meals or undertake activities like some of the other wards. The ward looked very tired in places and staff told us it took time to get repairs done.

Medical care (including older people's care)

Patients with neurology conditions did not have access to frequent wards rounds by neurologists as these were only twice weekly. Cover was provided by eldercare consultants. This was due to the trust not having enough neurologists. Staff told us they were able to contact the neurologists for advice and guidance about patients, but they did not have the capacity to undertake daily ward rounds. The trust was working hard to try and recruit to the vacant posts they have for neurologists.

On one of the medical wards, we visited, we found a patient who was inappropriately placed. This patient had no medical needs and was in hospital due to social reasons. Whilst the ward had involved other health and social care professionals, it was taking long to find a suitable placement which was out of the control of the trust. This patient was cared for in a side room with no facilities, for example, TV or en-suite. During our inspection, we observed the member of staff allocated to provide care and support was not interacting with them or providing them with activities suitable for their needs. This was raised with senior staff for the trust who said they would be speaking with staff to make sure they meet the needs of the patient.

Access and flow

Patients could access the service when they needed it but did not always receive the right care promptly due to pressures on services and bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages. Some patients were needing longer stays while they awaited treatment.

Patients could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. The hospital had significant capacity problems with a lack of available beds. At the time of the inspection, there were 103 patients who were medically fit to go home but there were no social care packages immediately available or care/nursing homes able to meet their need for discharges to be carried out safely. The situation was made worse by patients testing positive for COVID-19 which led to 122 beds being closed on the day of the inspection.

Patients were often delayed for discharge due to reduced capacity with social care. There was a lack of domiciliary care packages for patients who had complex needs and required frequent visits throughout the day. This was due to staffing shortages. Some patients' discharges were delayed due to lack of specialist care in a nursing or care home for patients with mental health care needs. Senior staff told us some additional beds for patients living with dementia would become available in the community by the end of October 2022 and this would enable some patients wating for this specialist care to be discharged.

Some of the medical wards had extra patients on them to help meet the demand for their services. The senior staff from the trust had made the decision to ‘board’ some patients on some medical wards and patients were often in areas without any privacy. For example, on one of the medical wards we visited, a patient was on a bed in the main corridor. They had no privacy as staff, other patients and visitors walked past them. Senior members of staff we spoke with were aware of the impact this had on patients but explained these measures were taken when they were in escalation and to improve flow in the hospital. A standard operating procedure (SOP) had been devised by trust for staff to follow when they needed to board patients. This listed areas that could be used for boarding patients and the agreed numbers. The boarding model they were developing had been used in another trust to ensure boarding was carried out at certain times of the day for consistency and to maintain flow.

Demands for beds in medicine often outstripped the number of beds available when the trust had increased pressure on their services. When capacity within services was pressured, the trust used areas for overnight care that were not always

suitable for patients and lacked some facilities. For example, the same day medical assessment unit (SDMA) was meant to close at 02.00am with last patient accepted at 22.00 each day and be used for short stays. Due to the increased pressure on bed capacity this was not always happening. We saw one patient had been on this unit for over seven days, this unit lacked facilities for washing and areas to store personal belongings and no tables to help patients when eating. Other areas used were also not designed for patients to stay overnight and lacked facilities included the discharge lounge.

The Acute Medical Unit (AMU) was meant to be a short stay unit (24-48 hours) where plans for patients' treatment and care were devised and then the patient was transferred to the ward which was able to care for their specific medical need. Due to the increased pressure on bed capacity this was not happening. We saw one patient had been on this unit for nearly seven days.

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

Managers and staff started planning each patient's discharge as early as possible. Ward leaders and staff started planning each patients discharge as early as possible. There was a discharge coordinator who supported discharge planning on the ward we visited. A discharge coordinator monitored patients who were waiting for discharge and fed information back to senior staff about any delays. Any additional support needed by the patient once home, for example, by the community nurses, would be arranged by a qualified nurse on the ward.

Is the service well-led?

Inspected but not rated

Inspected but not rated

Leadership

Not all leaders on the wards had developed the skills and abilities to run the service. They understood the priorities and issues the service faced. They were not always visible in the service for staff.

Not all ward leaders had developed the skills, knowledge and experience they needed, as they were new in senior posts. They were being supported to develop and to help address the issues within the ward. A culture review had taken place with nursing staff to identify areas of improvement and areas where they were performing well. An action plan had been devised and this was to be monitored by the head of nursing via the care group board. An action plan had been devised and this was to be monitored by senior staff.

There were leadership arrangements to support the improvement of one of the medical wards. Senior nursing staff were supporting the ward leadership as they were a junior team. They understood the issues within the ward and were active and mostly visible to staff.

Some staff felt the ward leaders were not visible, but they felt they were approachable. Feedback we had received prior to our visit stated that the wards leaders spent most of their time in the office with door closed. This was also identified on the culture review. However, not all staff understood the role of the leaders on the ward, and this was an area where they needed to improve as they had identified this in the culture review. During our inspection the leaders on the wards were visible and one was assisting with mealtimes. They told us all staff assisted with mealtimes to make sure patients received their meals in a timely manner.

Culture

Not all staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture but not all staff could raise concerns without fear, or feel they would be listened to.

Some staff did not feel supported, respected and valued by the more senior staff. Wards were busy and more often short staffed which staff felt impacted on patient care. Some medical wards had a high turnover of staff and had difficulty in recruiting to posts. One medical ward had completed a cultural review prior to this inspection to help establish why turnover of staff was high and why it was difficult to recruit. This demonstrated some areas for the management team to address, for example, short staffing on shifts and lack of team working. We were sent some feedback by the trust from student nurses who had been on placement on this ward. This complimented the staff team but also highlighted the wards was mostly short staffed.

The culture was centred on the needs and experience of patients. Staff told us they came to work because of the patients. They told us they did their best each shift, but it was hard due to being short staffed. Not all staff felt they had enough time to meet patients need due to the staffing levels. Staff told us they worked 12 hour shifts but preferred this as it gave them more time off work. One member of staff had worked three 12 hour shifts in a row and told us it was hard work, and they were often very tired.

Most staff felt positive and proud to work in the organisation despite the pressure for the services provided by the trust and due to short staffing levels. However, staff on Tintagel ward felt the lack of upkeep of the ward and refurbishment plans impacted on their positivity.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. However, information received prior to the inspection said that not all leaders were always receptive to concerns and did not appear to take any action from these.

There were not always cooperative, supportive and appreciative relationships among staff on all the medical wards. The culture review highlighted for one ward, whilst individual groups of staff worked well together the whole ward team did not. Some staff felt this had improved at the time of the inspection.

Areas for improvement

MUSTS

Royal Cornwall Hospital medical wards

The trust must ensure that suitable equipment is provided in the escalation areas to meet the needs of the patients. Regulation 15 (1)(c)

Medical care (including older people's care)

The trust must continue to act to recruit to vacant roles across the organisation to ensure there are sufficient staff deployed to meet the needs of patients. The trust must also ensure staff are supported and have time to complete their mandatory training and additional training for their competency assessments. Regulation 18 (1) (2)(a).

SHOULDS

Royal Cornwall Hospital medical wards

The trust should ensure all patients records are completed in full, signed and dated by the member of staff writing them. This includes the use of food and fluid charts to help staff when monitoring patients input and output.

The trust should consider an upgrade of some of their wards to meet the ongoing needs of patients.

The trust should continue to work with system partners to discharge patients inappropriately placed to a more suitable placement outside of the acute trust.

The trust should continue with their action plan following the cultural review of one of the medical wards to improve staff moral and recruitment of new staff.

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	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing